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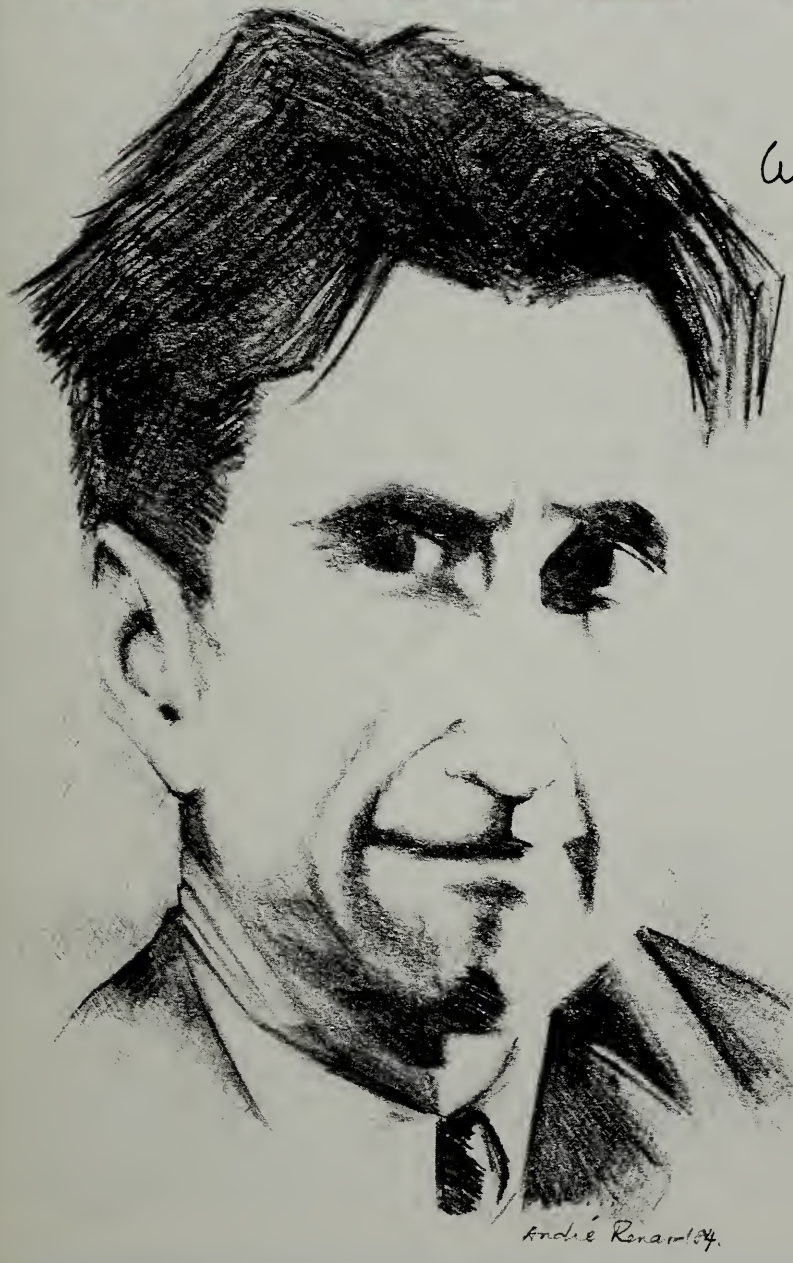
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This month's cover of *The Journal* depicts the arrival of 1984 and questions whether or not much of George Orwell's prophecies about Big Brother are coming true in the federal government's involvement in the practice of medicine. The cover is drawn by Andre J. Renard, M.D., a Jacksonville Plastic Surgeon and Cover Editor.

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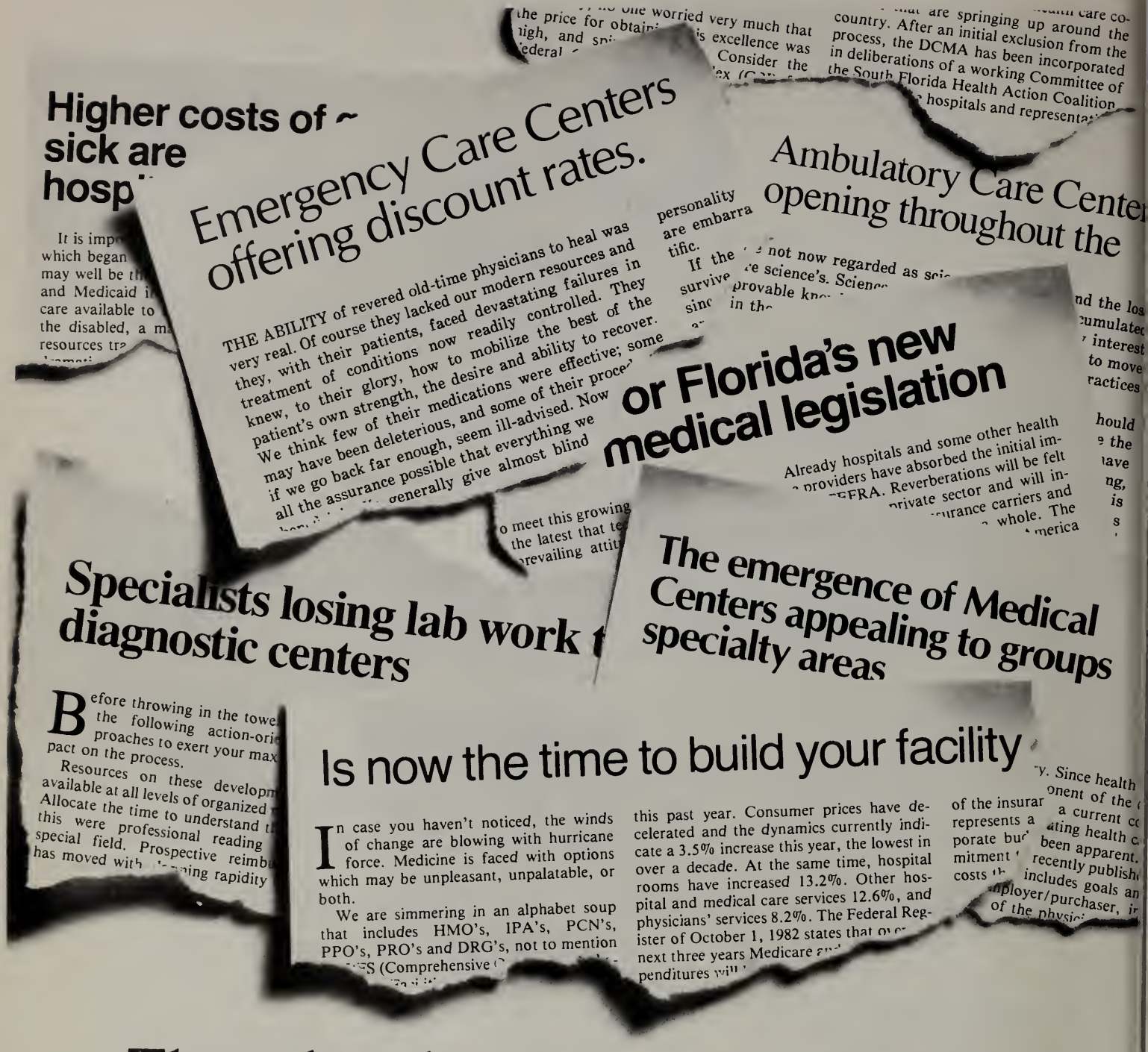
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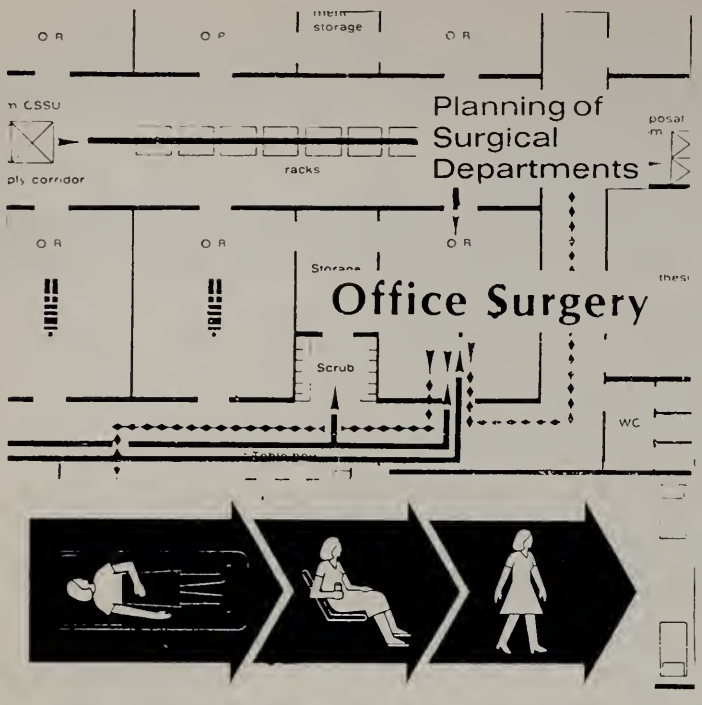
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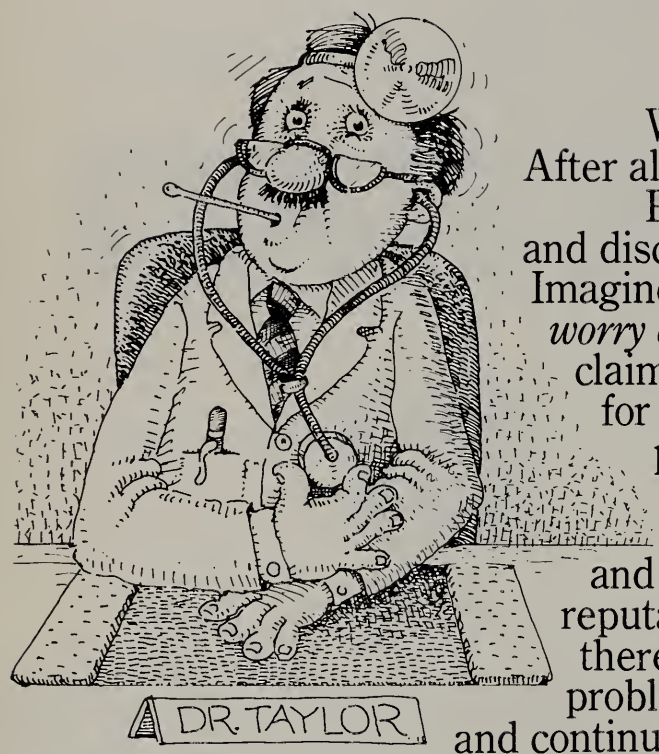
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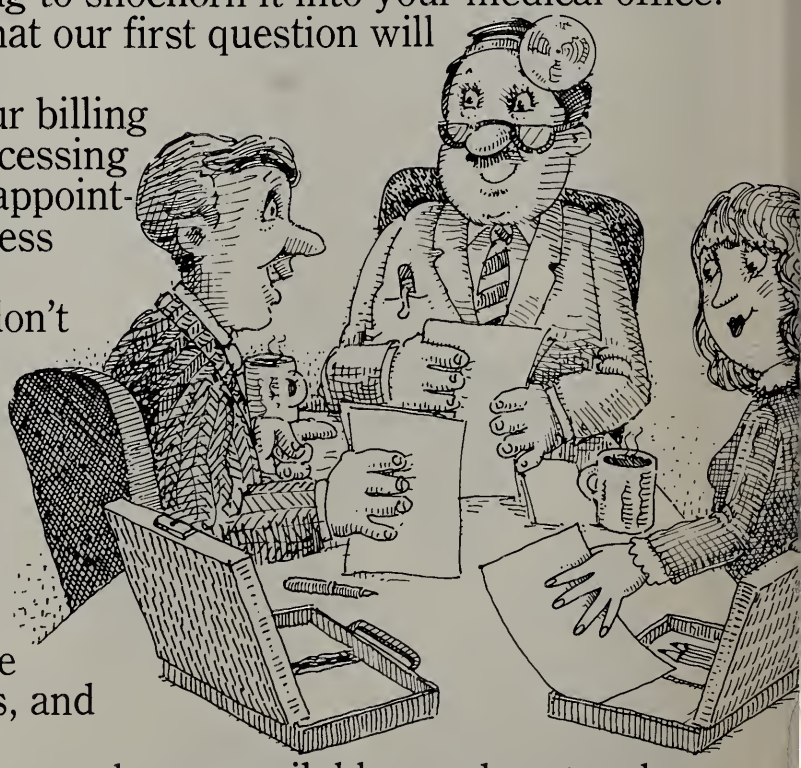
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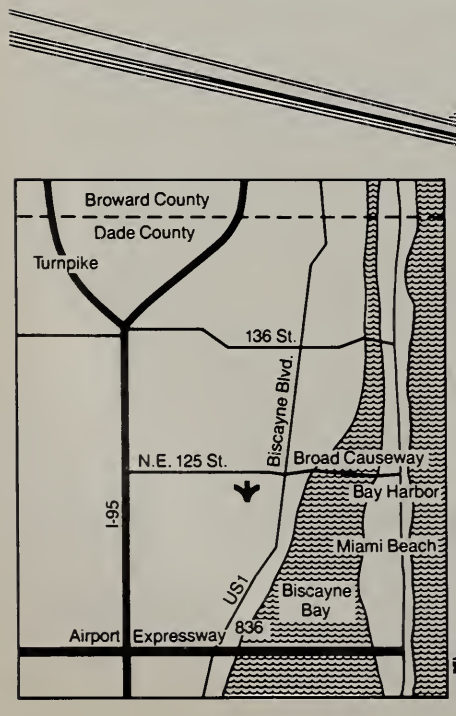
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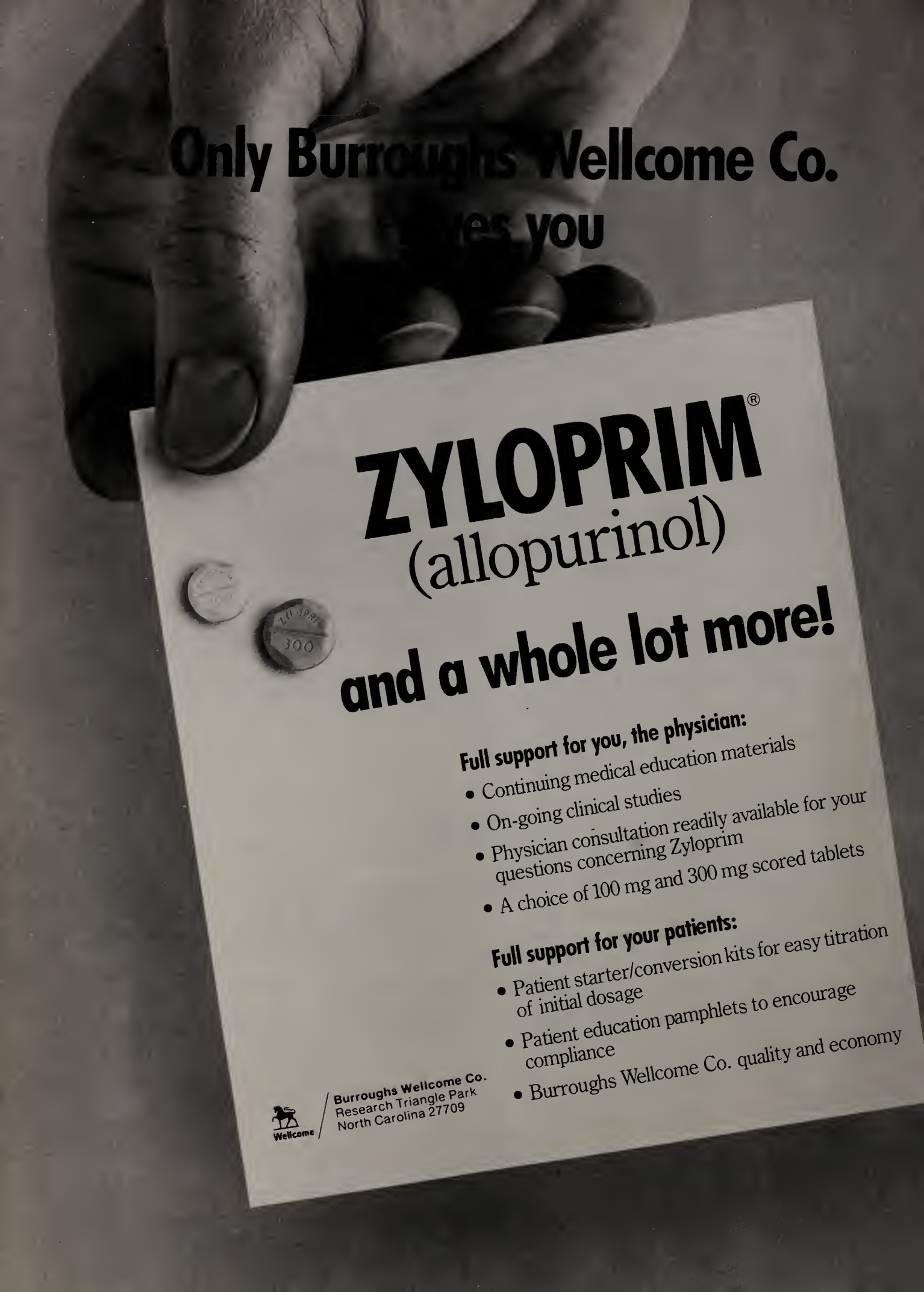
COVER

This month's cover of *The Journal* is a drawing by Jacques Le Moyne at Fort Caroline in 1564. The Timucuan chief, Outina, is pictured with his Shaman who is performing a ritual to determine the outcome of a battle. Reproduced by permission from the Trustees of the British Museum.

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Roche salutes the history of Florida medicine



THE ICE MAN OF APALACHICOLA

Dr. John Gorrie

Medical history is replete with statistics regarding deaths from fever, and before the middle of the 19th century, little could be done to aid the afflicted. Yellow fever, smallpox, typhoid and scarlet fever were scourges that came in epidemics and caused rapid elevation of body temperature from which, all too often, the victim died.

Even for sunstroke patients, lowering body temperature—when attempted at all—was rough and crude treatment consisting of dunking the victim, often fully clothed, into cold water.[1]

Patented invention

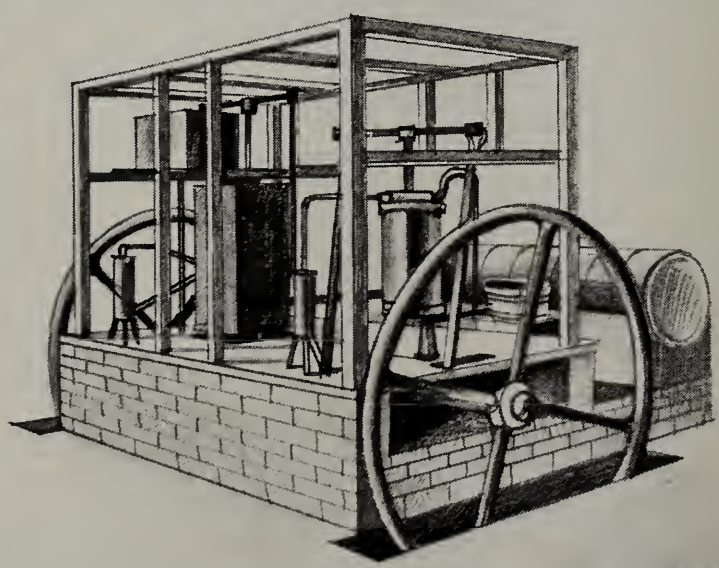
It was, therefore, a significant medical development when, on May 6, 1851, U.S. patent No. 8080 was granted to Dr. John Gorrie of Apalachicola for his mechanical refrigeration technique that perfected the process for making artificial ice.[2]

Dr. Gorrie installed his artificial ice machine in the United States Marine Hospital in Apalachicola;[2] there it came to the attention of other Florida physicians, who began to explore ways of using the ice-making process in preventing and treating yellow fever.[3]

Now a necessity

Today its medical applications are myriad—medications are kept fresh, foods are kept chilled, germs are kept under control, patients are kept comfortable and, often, treatments include applications of ice packs. All these conveniences and treatments—and more—are direct descendants from the historic invention of Dr. John Gorrie.





References: **1.** Headquarters: The hospital, chap. 7, in Lee RV, Elmerl S *et al: The Physician.* New York, Life Science Library, Time Inc., 1967, p. 149. **2.** Kane JN: *Famous First Facts,* 3rd ed.; New York, The H. W. Wilson Co., 1964, p. 518. **3.** Day SM: *J. Fla. Med. Assoc. 69*:719, 1982.

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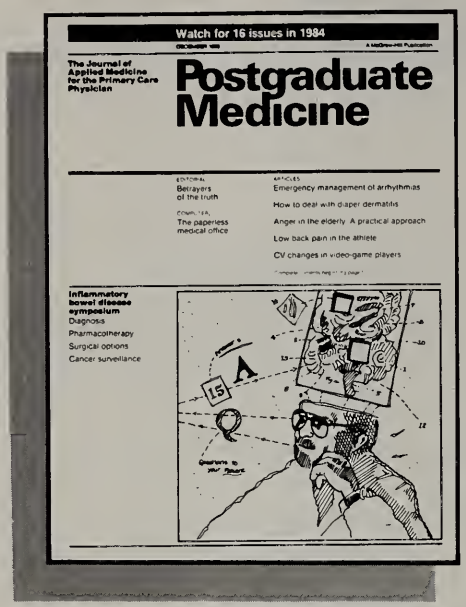
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Pharmacology of Calcium Channel Blockers
Arnold M. Katz, MD
Professor of Medicine
Head, Division of Cardiology
The University of Connecticut Health Center
Farmington, CT

Management of Hypertension with Calcium Channel Blockers: Hemodynamic Effects
Per Lund-Johansen, MD
Professor of Medicine
Section of Cardiology
Haukeland Hospital
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Calcium Channel Blockers and Hypertensive Emergencies/Crisis Situations
A. Gary Ellrodt, MD
Director of Medical Intensive Care
Cedars Sinai Medical Center
Los Angeles, CA

Calcium Channel Blockers and Hypertensive Urgency
Robert Davidson, MD
Associate Professor of Medicine
Department of Nephrology
Director of the Hypertension Clinic
University of Washington School of Medicine
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Acute Treatment of Hypertensive Emergencies with Calcium Channel Blockers
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Calcium Channel Blockers as Monotherapy in Chronic Hypertension
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This Symposium is supported by an educational grant provided by Pfizer Laboratories.

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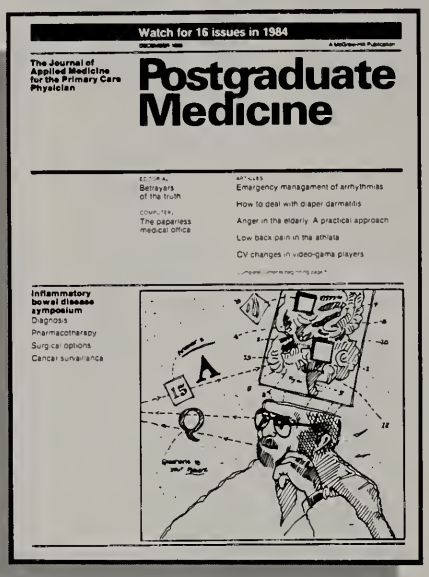
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This month's cover of *The Journal* is a signed and numbered print by Mrs. Dale (Toni) Charneco entitled "The Magic of Cherubs."

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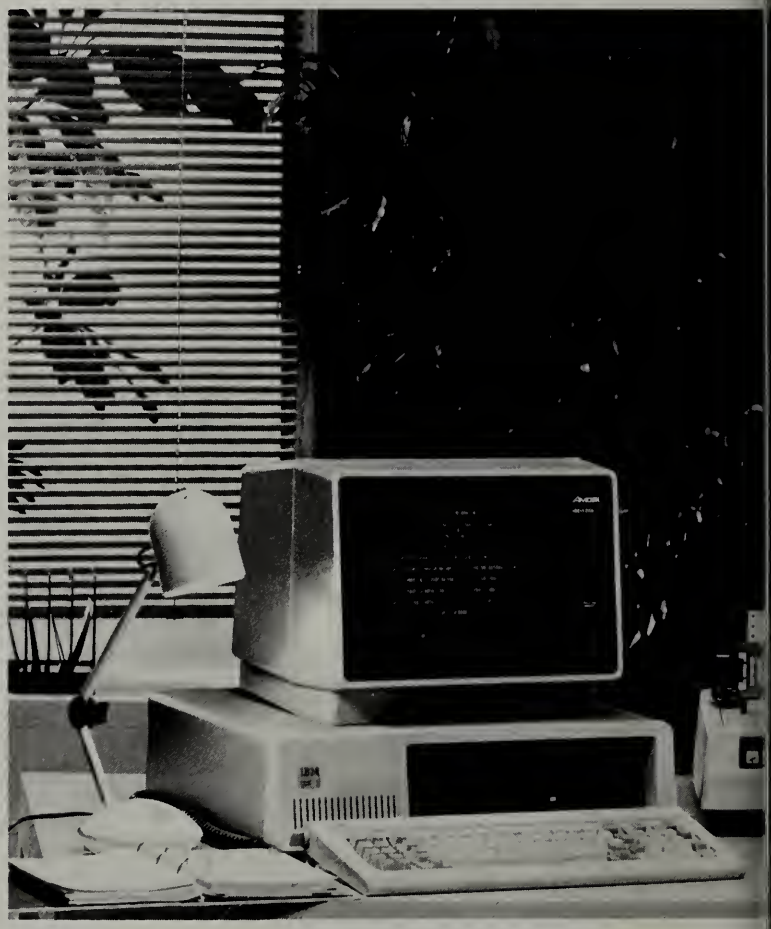
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FMF IMPAIRED PHYSICIANS COMMITTEE NEWSLETTER

Published by the Committee on Impaired Physicians / Florida Medical Foundation / P. O. Box 2411 / Jacksonville, Florida 32203

January 1984 "Doctors Helping Doctors" Vol. 1 — No. 1

Our First Issue

This is the first of what we hope will be many issues of the *Florida Medical Foundation Impaired Physicians Newsletter.* We are indebted to Dr. Daniel B. Nunn, Editor of *The Journal of the Florida Medical Association, Inc.* for making this space available to us for communication with the entire FMA membership.

IPN will be published quarterly, in January, April, July and October. We promise to be brief in providing you with interesting information you should know about our program and how it combats chemical addiction within the medical profession.

Meeting information and news of impaired physician activities at the local, state and national levels will be included in these columns.

We invite the comments and suggestions of our readers. Each month we will select a question from those we receive and attempt to answer it as completely and briefly as possible.

Comments should be addressed to: Committee on Impaired Physicians, Florida Medical Foundation, P.O. Box 2411, Jacksonville, FL 32203.

Guy T. Selander, M.D.
Chairman, Committee on Impaired Physicians

Edward D. Hagan
Editor

The FMA — FMF Impaired Physicians Program — Doctors Helping Doctors

Nationwide Search is Launched for Full-time IPP Medical Director

A nationwide search has been launched for a fulltime medical director to head the Florida Medical Association's three-year-old Impaired Physicians Program.

Employment of a fulltime director became possible last October when the FMA Board of Governors increased the program's budget by 140%, to $120,000 a year, according to Guy T. Selander, M.D., of Jacksonville, Chairman of the Impaired Physicians Committee.

"We are very grateful to the Board of Governors for its generosity" Dr. Selander said. "The Board has demonstrated in a very real and sincere way that it recognizes the problem of the impaired physician and wants to do something about it.

"The Board has been completely supportive all along, but this budget increase will allow us to strive for the highest degree of excellence in our program."

The Committee will accept applications until March 15, 1984 from prospective medical directors. Applicants must have an M.D. degree and a Florida medical license; be skilled communicators with administrative experience; be in good health, and have knowledge and experience in the field of addictionology.

Dr. Selander said the medical director's responsibilities and duties will include: administration of the impaired physicians program; evaluation of impaired physician treatment facilities; organizing and conducting educational programs for health care professionals and the lay public; serve as liaison with the Florida Board of Medical Examiniers and other professional boards and organizations; intervention with impaired physicians; and monitoring aftercare programs.

Salary is open, Dr. Selander said.

The new medical director will succeed Dolores A. Morgan, M.D., of Miami, who has served on a parttime and acting basis for more than three years. Dr. Morgan has expressed the desire to be relieved of her duties as soon as a suitable replacement can be found.

"Thank God for Dolores Morgan," Dr. Selander commented. "Without her and her loyalty and dedication, our program would not be anywhere near where it is today. She originally agreed to serve long enough to get us started and has served longer than she would have wished, but that's a mark of her character and loyalty."

Addiction Treatment Covered by FMIT

The Florida Medical Insurance Trust (FMIT) began providing benefits for treatment of chemical addiction effective November 1. The action by the FMA-sponsored FMIT fulfills a goal pursued for three years by the FMF Committee on Impaired Physicians.

FMIT said benefit levels will be the same as it currently provides for mental and nervous disorders. Treatment in specialty hospitals will be covered if the hospitals have been approved for treatment of impaired physicians by the FMF Committee on Impaired Physicians.

In-patient hospital and physician charges will be paid at 80% with a $25,000 lifetime maximum. Out-patient physician charges will be paid at 50%, with a limitation of 40 physician out--patient visits per plan year, also subject to the $25,000 lifetime maximum.

All other services will be paid at 80% (in-patient) and 50% (out-patient) with the $25,000 maximum.

The $25,000 maximum for in-patient hospital charges is separate from the $25,000 maximum for all other charges.

(Continued on Next Page)

Nationwide Search (Con't.)

Physicians interested in the position should send a letter of application and complete CV to: Guy T. Selander, M.D., Chairman, Committee on Impaired Physicians, Florida Medical Foundation, P.O. Box 2411, Jacksonville, FL 32203.

The Question Box

(Editor's Note: Each month, a commonly asked question will be answered in the *Newsletter.* If you have a question you would like to have answered, send it to: FMF Committee on Impaired Physicians, P.O. Box 2411, Jacksonville, FL 32203.)

Q. Does the FMA-FMF Impaired Physicians Program handle all types of physician impairment? **H.D.E., Jacksonville.**

A. Unfortunately, no. Existing policy adopted by the FMA House of Delegates limits the program to alcoholism and drug addiction. However, when the cause of impairment is determined upon evaluation to be organic brain syndrome or some other factor, efforts are made to refer the physician patient to an appropriate treatment source outside the program. Perhaps someday the program will be expanded to cover all types of impairment.

Journal Article Relates History of IP Program

A history of the FMA-FMF Impaired Physicians Program is included in the October 1983 issue of *The Journal of the Florida Medical Association, Inc.*

The article was written by Committee Chairman Guy T. Selander, M.D., of Jacksonville and a Committee member, Mrs. B. David (Edie) Epstein of Key Biscayne. It's entitled "The FMA-FMF Impaired Physicians Program: The First 25 Months."

In case you missed it, you may obtain a copy of the article by contacting the Committee at the FMA Headquarters in Jacksonville.

Four Florida Hospitals Approved For IP Program Participation

Four health care facilities in Florida have been approved by the Committee on Impaired Physicians to receive and treat physicians and other professionals under the IPP.

They include: South Miami Hospital; Palm Beach Institute and its affiliated facilities, the PBI Hospital Program of Jupiter and The Friary on Pensacola Bay, Gulf Breeze; Lakeland Regional Medical Center; and Horizon Hospital, Clearwater.

Sometimes patients are referred to facilities in other states, particularly Georgia and Mississippi.

In evaluating treatment facilities for inclusion in the program, the Committee requires that they have at least four years of experience in treating chemical dependency cases.

Facilities also are expected to be accredited by the Joint Commission on Accreditation of Hospitals; have active physician involvement in the treatment program; participate in Alcoholics Anonymous and Narcotics Anonymous; and offer aftercare and family centered care programs.

Local Committees Are Essential to Program

County medical society impaired physicians committees play an important role in the operation of the FMA-FMF Impaired Physicians Program.

Their functions include identification of, and intervention with, impaired physicians and encouraging them to submit to evaluation and treatment. They also are valuable in the periodic monitoring of impaired physicians during the rehabilitative and after-care period.

Impaired Physician committees currently exist in 26 of the Florida Medical Association's 46 county medical societies: Alachua, Bay, Brevard, Broward, Capital, Collier, Dade, DeSoto-Hardee-Glades, Duval, Escambia, Hillsborough, Indian River, Lee, Manatee, Martin, Orange, Nassau, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, Taylor, Volusia, and Washington.

Speakers Are Available For Medical Meetings

Does your hospital medical staff, county medical society or state specialty group need a speaker to fill an open meeting date?

If so, why not consider a program on the FMA-FMF Impaired Physicians Program?

The Committee on Impaired Physicians will furnish a speaker at no cost to the sponsoring group. Presentations can be tailored to suit the organization's needs — as short as 15 minutes or as long as an hour.

For information, contact the Committee at the FMA Headquarters in Jacksonville.

Confidential Telephone 'Hot Line' is Available

As a means of facilitating the reporting and treatment of the impaired physician, the Committee on Impaired Physicians maintains a telephone "hot line".

The "hot line" number is (305) 667-8717; it rings into the Miami office of IPP Medical Director Dolores A. Morgan, M.D., and is answered only by her. During times she is not in the office, calls are recorded by an electronic answering device, which also is operated only by Dr. Morgan.

If you know a physician in trouble with alcohol or drugs, do him a favor and call the "hot line": 1-305-667-8717.

Professional Education Is Committee Function

One of the functions of the Committee on Impaired Physicians is to provide the profession with current scientific information on chemical addiction.

As one means of accomplishing this, the Committee has sponsored for the past three years a Section on Chemical Dependency at the FMA Annual Meeting. Each session features nationally-known authorities in the field of addiction treatment.

The fourth annual Section on Chemical Dependency will be conducted on Thursday, May 3, during the 110th FMA Annual Meeting at Lake Buena Vista. Program details will be announced later in the *Newsletter,* as well as other FMA publications.

PRESIDENT'S PAGE

1984



The holidays are over and the new year has begun. A new year to most of us represents a new chance, a new start. Many of us mentally, if not formally, start each new year with some new commitment or resolution. And, somehow, we are able to leave each old year forgiven if we are unable to fulfill the resolutions made at the beginning of the year.

The year 1984 promises to be a historical year for medicine. The changing views of society have been presented in a book entitled, *1984*, written in 1949 by George Orwell. A recent review of Orwell's book has revealed some of his worst predictions to be true much in the same way many of the Buck Rogers space fantasies are now true.

1984 will be a bumper year for the continued assault on medicine. The cost of medical care is now a national presidential campaign issue. There is every reason to suspect the Florida Legislature to take some action in the regulation of the cost of health care. Rate regulation for hospitals is already a prefiled bill. Reimbursement to hospitals under the Medicare prospective payment system (Diagnostic Related Groups — DRGs) is already a reality. Preferred provider organizations and health maintenance organizations are flourishing only because physicians are joining. We, as physicians, have no experience at negotiations, and we are agreeing to "do more for less."

The competition of other paraprofessional groups for the practice of medicine will increase. Already, pharmacy, nursing, physician assistants, physical therapy, lay midwives are saying "let me practice, too." To confront the professional liability problem will require all our collective energy and effort without the sureness of success.

Other items will be added to the inventory of issues that will confront, confuse and chip away at the principles and manner in which medicine is practiced. But the worst problem of all is our, medicine's, disorganization and lack of unity. We cannot respond to the many foes of medicine individually. We must respond strongly and collectively. . .and, we are only as strong as our weakest link. We must inform ourselves and remain informed. We must be participants and not observers. We must work hard, together, to protect and preserve the best health care system in the world. But, all will be lost unless we inform our patients by "showing and doing." Our patients, our friends, our neighbors must have no doubts or be confused about the quality of their health care system.

And so, my friends, let's accept the challenge of '84 and go to work — together.

J Lee Tackett

A WORD TO THE WHYS

WHY AMA? AMA-sponsored Group Disability insurance is designed to replace a substantial portion of your income should you be unable to practice due to sickness or accident. Unlike many policies, AMA-sponsored Disability Insurance provides benefits if you are unable to perform *your* occupation in *your* medical specialty. Providing you with benefits you can't afford to be without: it's one more good reason why you should be a part of the AMA.

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1984 is here

It is 1984, and the medical scene is bursting with a kaleidoscope of new names, new rules, new bureaucracies, and new expectations. Within the last few years, a mind-boggling array of developments has sprung up that ineluctably will change the face of medicine forever. The impetus for these changes has been the soaring cost of medical care, and it is already revolutionizing medical practice like nothing has before. There is more bad news: Big Brother has just begun the job, and more changes are on the way. If George Orwell had focused on medicine instead of politics when he wrote the epic novel *Nineteen Eighty-Four*, he would have been on target.

Until a year or two ago, few physicians had heard of TEFRA, DRGs, PRS, IPAs, EPOs, PPOs, and a jumble of other weird-sounding acronyms. Physicians have been aware for sometime of the escalating cost of medical care, and of the attempts, particularly by the government, to curb the spiral. But little did they expect to be hit by a deluge of so many things within such a short period of time. What makes matters worse is that many of the proffered remedies are nothing more than simplistic concoctions.

Because it foots the bill for close to 40% of the yearly expenses for medical care, the government has a vested interest in keeping expenses down. The first rumblings of federal intrusion was heard in the late 60s. At that time, Senator Edward Kennedy led an attempt in Congress to experiment with socialized medicine; but the attempt failed, mainly because of the efforts of the American Medical Association. It was clear from the experience of Great Britain, Canada, and Sweden that socialized medicine was not what Americans wanted. Nothing more was heard about it after the abortive try in Congress.

The tinkering for a panacea by Congress and other politicians, however, did not end. Richard Nixon, while president, worked for the passage of legislation which created the HMOs, followed later by the HSAs and the PSROs. The HMO movement was premised on the theory that the traditional system of delivering medical care contained incentives that inflated costs; HMOs, by altering the system as well as the financing mechanism, would provide incentives for more efficient, cost-conscious care. As it turned out, few Americans joined what was expected to be a bandwagon, and many of the HMOs, that were formed were financial failures and had to be disbanded. The reception to HMOs continues to be lukewarm at this time. The HSAs and the PSROs, in the meantime, have been phased out.

But while it was not a spectacular success, the HMO movement spawned the birth of a new catchword in the 70s and 80s: competition. It had a simple but majestic appeal to those who had seen it work as a fundamental economic law. Competition, at least by those who embrace it, would take two forms: competition among various health providers, and competition among a number of health delivery systems. One logical offshoot of this development was the tremendous increase in the number of medical students, doubling from 1970 to 1980, with the now well-known projection by GMENAC that we will have a surplus of 70,000 physicians by 1990. In a parallel move, an assortment of non-M.D. practitioners started a spirited campaign to win privileges as independent practitioners. Meanwhile, to give patients a variety of choices, new methods of providing medical care were born: PPOs (Preferred Providers' Organizations), EPOs (Exclusive Providers Organizations), and PCNs (Primary Care Networks).

Competition, after over ten years, is not what it was billed to be. Politicians made the mistake of assuming that the medical marketplace would behave like the economic marketplace; it did not and it never will. Each surplus physician, in fact, was found to generate close to $250,000 of extra costs per year to the government. Doling out privileges to non-M.D. practitioners, on the other hand, had not been proven to make any economic sense, or any sense for that matter. The PPOs, EPOs, and PCNs are too new to make any judgment at this time, but they appear to be nothing more than disguised forms of discount medicine.

The latest bureaucratic gimmick to appear on the scene is the prospective reimbursement system through the so-called DRGs. Started in October of

last year and slated to be phased in over a period of four years, the DRG program was conceived ostensibly to promote efficiency, cut waste, and reward those hospitals which do a good job. By 1985, Congress is expected to extend the same concept to physicians. Although it was tried on a limited basis in New Jersey, there is no clear-cut evidence to indicate that it would work well on a national scale. Physicians are justifiably concerned that the fiscal constraints of the program may lead to short-cuts and compromise their ability to deliver excellent medical care.

The bureaucratic game is not over yet. In the offing is a proposal in Congress to make physicians accept mandatory Medicare assignments or they do not get paid at all. Medicare faces potential bankruptcy in three years, and President Reagan wants a reduction of $2 billion for a starter. Physicians are convenient scapegoats and will be the targets in the next Congress unless they resist this latest effort to castrate them.

The continuing but elusive search for effective cost containment will inevitably lead to the erosion of what is acknowledged as the best system of medical care in the world. There are signs that the erosion is already starting. If physicians do not stem the onrushing tide, a tragedy of Orwellian proportions will surely be upon us.

R. G. Lacsamana, M.D.

A wish for 1984

The depressingly long list of world disasters, of wars in the Mideast, of continued unemployment, starvation in underdeveloped nations, a spiraling arms race generating a universal sense of insecurity and fear of nuclear devestation; last years sheer volume of bad news makes it impossible for anyone but an unreconstructed optimist to speak of a happy new year. Yet for 1984 how can one be otherwise? The world over, politicians, statesmen, the ordinary citizen, mothers and children, all in the deepest recesses of their hearts, share the same simple hopes: that in the new year mankind will be wiser than he was last year, kinder, gentler, more caring, that he will learn to trust more, to give more, to do more, to create more, to love more, so that the world he passes on to future generations will be a better one than the one he received.

Or in 1984, will more people live in a completely totalitarian environment with a controlled economy under governments where words and language are used to erase thoughts, and to manipulate people? Will there be countries where the official language is a bureaucratic babble using words as a tool of state craft so that forbidden ideas cannot be expressed for there simply are no words for such thoughts and the lanugage eventually becomes so constricted that forbidden thoughts are unthinkable. Yet men are slowly learning that because two nations think differently neither need be wicked and words and language and human speech can be used to bless, to love, to build, to forgive but also to torture, to hate, to destroy or to annihilate.

Though others may have accumulated more money, are more handsome or smarter, still when it comes to the rarer spiritual qualities such as charity, self-sacrifice, honor, nobility of heart, each of the world's inhabitants has an equal chance with everyone else to be the most beloved and most honored, for its often surprising to find what heights may be obtained merely by remaining on the level.

What one man achieves may or may not be important now, but for the future, what one is, how one relates to family and friends and the world at large is a permanent index of character and worth. However one life touches another, one helps or hinders, one makes the other stronger or weaker, dragging the other down or lifting him up. And so somehow a desire must be instilled in every man and woman to sincerely and passionately seek for the safety, the welfare and the free development of the talents of all the world's people. Even though a small part of mankind strives for such goals this will prove itself in the long run, for universal is the dissatisfaction of man with himself and his striving to be better than he is, as the purpose of man and society is to safeguard human dignity and the freedom of every individual.

Never growing up is childish yet not to know maturity is lack of education — for the aspiration of us all should be to never mentally grow old, but to keep the senses alert and the spirit alive, as long as the biological machinery holds out, and so retain a spirit of wonder and delight, remaining open to the world and to new ideas, accepting what is new and different without repudiating what is old and dear.

Those who rest most easily within themselves are those who have found the niche made just for them in whatever field, so long as it gives them a sense of being needed, of being purposeful and of doing some job a little better than most others can.

Wishing for the new year a freedom from pettiness, from vanity, from contentousness, respectful of the feelings of others and dedicated to some purpose outside and greater than oneself, such traits and virtues used as a touchstone for judging one's own conduct combining the serenity of a sage with the docile innocence of the child, should make 1984 a very good year.

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Further experience with ambulatory EEG monitoring

Jacob Green, M.D., David Scales, M.D., James Nealis, M.D., Ashley King, CRET

Simultaneous 24 hour ambulitory EEG and EKG recordings appear to be a valuable modality in the differential in patients with "blackouts". Interestingly in our study of 100 patients both EEG and EKG abnormalities increased with advancing age.

Continued experiences[1] with a clinically useful and effective means of ambulatory neurophysiological monitoring are described in order to better document a possible diagnosis of epilepsy in a variety of patients suffering from "blackouts".

Materials and methods • An Oxford Medilog system of preamplification, amplification and recording of EEG and EKG was used and Polaroid pictures were taken of data directly from the CRT viewing oscilloscope for permanent recordings. All patients' recording tapes containing both EEG and EKG data were stored for future reference.

As in our previous report,[1] three individual paired sets of preamplifying electrodes were utilized with no common reference electrode. We attempted to conform to the international 10-20% system of placement. Standardized recordings of cerebral electrical activity were made in all cases (Cz-left to T3, T3' to T4' and from T4 to Cz-right) (Fig. 1). Additional biophysiologic information was gained from an EKG (standard lead 2) to assess possible cardiac dysrhythmia as a cause for blackouts.

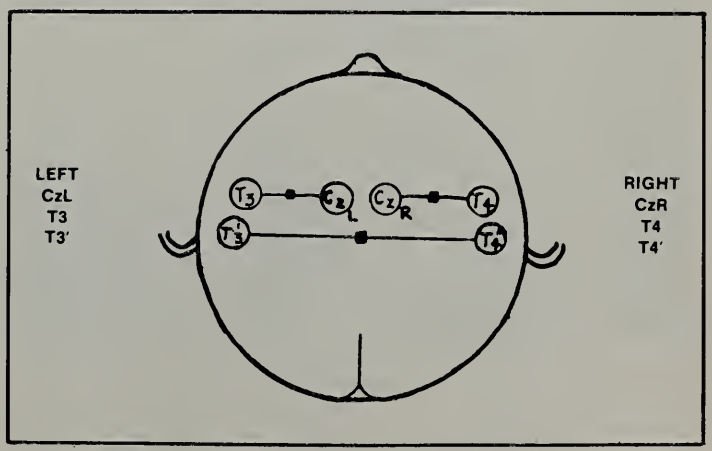


Fig. 1. — Diagram of cerebral montage used.

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Findings of the 24-hour ambulatory neurophysiological data obtained on each patient were then compared to their clinical histories and also to the standard multichannel EEG recordings. In every standard EEG we utilized the international 10-20% system of electrode placement (with 21 electrodes). Each patient kept a written historical log and neurophysiological EEG and EKG data 24 hour sampling was obtained. This log was in each incidence reviewed prior to and during analysis of all recorded data. The patients and/or family after instruction inserted an electrolyte gel solution into the electrodes previously applied on the head (every eight hours) into the recording period. Initially electrodes had been meticulously fixed to the scalp by the colloidian method (Fig. 2). Each complete recording was reviewed by a certified technologist, physician assistant, and board certified neurologist-electroencephalographer. During the EEG visual display review process, audio signals generated by the data tape are also evaluated. We selected the T3'-T4' channel for ongoing audio evaluation because, in our experiences, this most likely shows dramatic changes in frequency responses and cues the reader just prior to any visual pattern changes on the CRT scope. As described in our previous report, artifacts are highly recognizable by this recording montage.





Lateral view

Fig. 2. — Patient with electrodes attached.

Results • Our group of 100 patients included males and females from one year to 85 years of age, some with a tentative diagnosis of blackouts and, therefore, possible seizure disorder. No patients with documented prior diagnosis of seizure disorder were included.

Because of significant differences anticipated in the diagnosis of seizure disorder for different age groups, we arbitrarily divided our patients into three groups, 0-40, 40-60, and 60-above. This distribution best correlated with clinically expected findings, age 0-20 "seizure" most suspect, age 60 and above EKG abnormality most likely suspect.

The recording of EEG data was considered abnormal if the patient had clearly identifiable bursts of paroxysmal activity two times higher in voltage than surrounding background, either lateralized or generalized as depicted in the data recorded (Fig. 3). The EKG abnormalities were so labeled (abnormal) if multifocal PVCs or periods of asystoles lasting two or more seconds on the recording were noted. (Fig. 4). The results of our study follows:

"Blackout" patients with recorded normal standard EEG and recorded abnormal 24 hour ambulatory EEG data:

0-40	13 of 53	(24.5%)
40-60	11 of 26	(42.3%)
60-over	3 of 21	(14.2%)

These data tend to show the relative increased finding of abnormal EEG data information on a prolonged 24-hour recording including four to eight hours sleep. It should be noted that the original standard 8-14 channel EEGs did not, in every case, contain sleep but each of the records were obtained for periods of EEG recording time from 30 to 60 minutes.

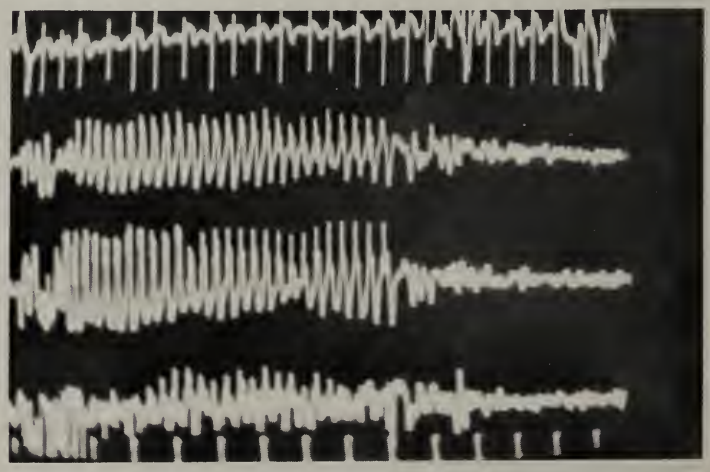


Fig. 3. — Abnormal EEG — burst of paroxysmal activity.

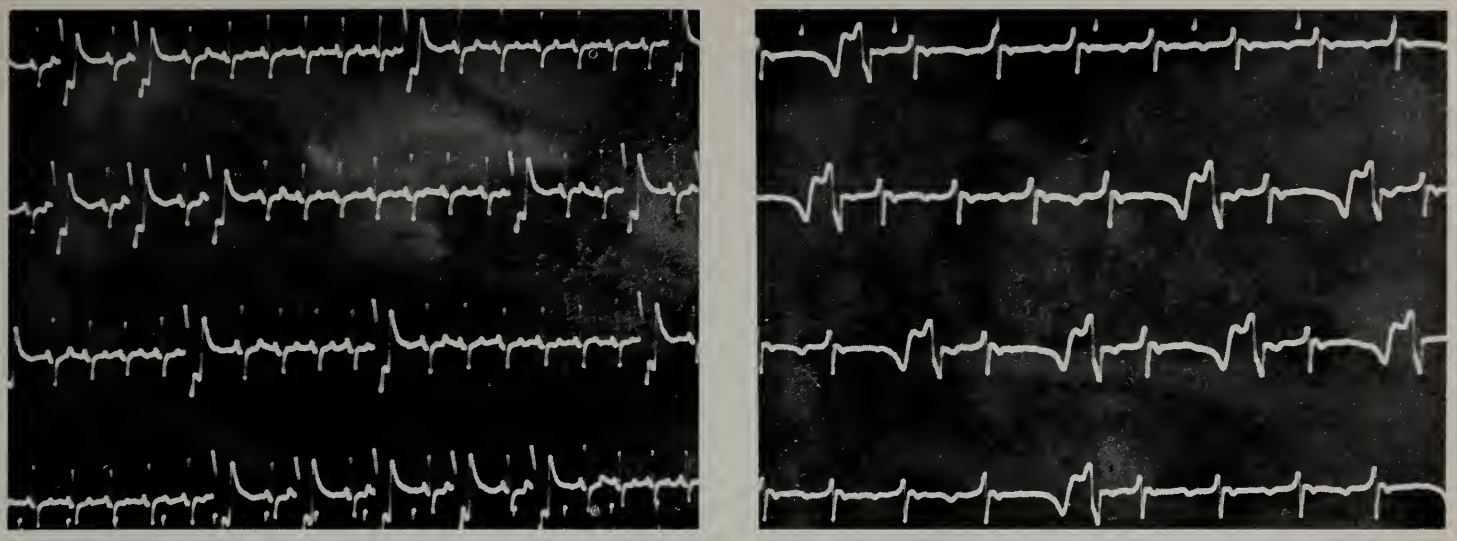


Fig. 4. — Abnormal EKGs. (Left) abnormal EKG live, picture [5] 60 second recording. (Right) close-up for detailed analysis.

Analysis of simultaneous recorded EKG data showed the following information.

0-40	9 EKG of 53 abnormal	(17%)
40-60	4 EKG of 26 abnormal	(15%)
60-over	8 EKG of 21 abnormal	(38%)

These data suggest increased frequency of abnormal EKGs in the older population. Somewhat unexpectedly nine of 53 patients from the 0-40 group also had abnormal EKGs by our criteria. This overall group of "blackout" patients also included those with both normal and abnormal EEGs.

A third analysis of data was carried out to ascertain abnormal EKGs in patients with both clearly normal 24 hour EEGs and normal standard EEGs. The results are as follows:

0-40	3 of 23 had abnormal EKGs	(15%)
40-60	1 of 10 had abnormal EKGs	10%)
60-over	6 of 10 had abnormal EKGs	(60%)

It appears from this data that an increasing number of abnormal EKGs occur with increasing age in patients with "blackouts" as a clinical diagnosis. Interestingly, it appears to be a fact that with increasing age both EEG and EKG tended to be more frequently in the abnormal category.

Discussion • Ives and associates initially described the technical features and value of 24 hour EEG ambulatory monitoring in a patient with dizziness and epilepsy in 1977.[2] Other authors reported early experiences with the clinical utilization of this monitoring noting the need to establish a diagnosis of epilepsy as firmly as possible.[3,4]

Use of our ambulatory neurophysiological information sampling system (portable cassette) has allowed us to futher define the data obtained in patients with possible seizures ("blackout patients"). We have continued to utilize temporal to temporal lobe montages with our currently limited array of six electrodes because of the clear-cut increased probability of temporal lobe (abnormal) findings in patients with probable seizures. Further experience also has again shown that when sleep is included in the long real time monitoring of EEG, an increased number of abnormal EEG findings may be anticipated. Patients with blackouts who had changes in EKG and EEG have been previously documented.[5,6]

These biophysiologic recording mechanisms, described to date, have sufficiently withstood the test of time and increasing patient use to state that they appear to be a useful tool in the diagnosis of possible epilepsy and/or syncopal episodes (blackouts).

Conclusion • Corroboration of our initial experience[1] with Oxford ambulatory cassette nontelemetry EEG monitoring along with simultaneous EKG evaluation has been accomplished. The methodology appears to be most useful in the patient with a possible seizure disorder. Consideration for both EEG and EKG abnormalities appearing simultaneously must be made in that bimodal physiological abnormalities[5] may in fact occur. It appears that both abnormalities in the EKG and EEG (as recorded) increase with advancing age. This finding requires further differentiation in "blackouts" as a clinical entity.

References

1. J Green, et al: Clinical Utility of Ambulatory EEG Monitoring, Clinical EEG, Vol. 4, 1980, pp. 174-197.
2. Ives, J. R., et al: Contribution of 4 Channel Cassette EEG Monitoring to Differential Diagnosis of Paroxysmal Attacks, Advances in Epileptology, 12th International Epilepsy Symposium, presented by D. L. Graham and J. K. Penry, Raven Press, New York, 1981.
3. Guada, J. A and Penry, J. K : EEG Monitoring in Patients with Absence Seizures, Epilepsy, The Vancouver International Symposium, 10th Epilepsy International Symposium, September 1978, Raven Press, New York, 1979.
4. Store, G Ambulatory EEG Monitoring in Neuropsychiatric Patients Using the Oxford Medilog 4 — 24 Recorded with Visual Playback Display, published ISAN 1979
5. Chi-Wian-Lia and Zeigler, D. K.: Problems Solved by Continuous Ambulatory Simultaneous EEG/ECG Recording, Neurology, 31:1152-1154, 1981.
6. Chen Wai Lia; Strong, A. and Ziegler, D.: Continuous EEG Recording, Kansas M.S.J., March 1981, pp. 107-110, #3.
7. Stores, G. and Lwyn, R.: Study of Factors Associated with Recurrence of Generalized Seizure Discharge and Seizures with Epilepsy Utilizing the Oxford Medilog System and Ambulatory Monitoring, Advances in Epileptology, 12th International Epilepsy Symposium, Raven Press, New York, 1981.

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Epididymitis in the workplace

Harold Baumgarten, M.D.

ABSTRACT: This article deals with the highly controversial subject of epididymitis as a workmen's compensatable injury. Experience is related with 50 cases of on-the-job epididymitis over the past seven years using specific diagnostic criteria and methods of treatment. Forty-one patients (82%) recovered within six days on the average and returned to work; the other nine (18%) were referred to a urologist, three required surgery for testicular torsion, three had prostatitis with prolonged syptamatology, and the other three were malingerers. Using proper criteria, epididymitis should be treated as a bona fide occupational related injury.

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In the practice of occupational medicine, consideration of epididymitis as a work-related injury has led to much controversy. Wesson vehemently opposes the hypothesis that epididymitis could possibly be caused by strain or trauma.[1,2] Others such as Lewis and Palmer,[3] Kohler,[4] Andur,[5] and Hughes[6] find less difficulty with epididymitis secondary to strain. They explain that strain (Valsalva maneuver) might cause a reflux of urine from the bladder into the vas deferens and tail of the epididymis where an aseptic inflammatory process is incited.[4]

In over 20 years of practice in occupational and family medicine, I have always considered traumatic epidiymitis and epididymo-orchitis as legitimate compensatable workplace injuries, especially with the presence of ecchymosis or hematoma. However, only for the past seven years have I and some of my local colleagues treated epididymitis secondary to strain as job-related. I have set up diagnostic criteria for myself that I consider fair to the injured employee and the workmen's compensation insurance carrier. These criteria are:

1. Recent history of lifting (strain) within 48 hours
2. No fever
3. Negative urinalysis
4. Vague pain in the lower abdomen
5. Tenderness of epididymis to palpation

Using these criteria, a review of the files of my last 50 patients with epididymitis revealed that their median age was 23 years. Nine had to be referred to a urologist, three of them had testicular torsion and required surgery. The other six had prolonged symptomatology and recurrences, three were proven to be prostatitis and three malingerers. The remaining 41 patients recovered on the average within six days

and returned to work, many within three days. The patients not satisfying my criteria were referred to their private physicians to be treated under their company's group health policy. Many were found to have gonorrhea. It should be remembered that testicular tumor must be searched for and carefully ruled out.

Treatment • My present treatment for epididymitis is prednisolone acetate 50 mg intramuscularly (only in patients not having hypertension, diabetes, peptic ulcers, tuberculosis, or anxiety problems), oxyphenbutazone 100 mg by mouth four times a day for three to five days, doxycycline 100 mg by mouth twice each day for five days (rationale for antibiotics is questionable),[3] ice packs and elevation of the scrotum during bedrest for the first 24 to 48 hours followed by warm sitz baths from the second to third days.

Wesson[1,2] and others[7] have always believed epididymitis to be caused by infection of pyogenic or tubercle organisms and that strain is more or less coincidental or "self-devised" for secondary gain. If I accepted their beliefs, I would not be able to treat the secondary infections found with chemical or contact dermatitis, chemical inhalations, and various contusions and hematomas as on the job occurring injuries. Even the most common of industrial accidents, back sprain, is almost always treated as job related even though it may be coincidental to obesity, arthritis, and "self-devised" for secondary gain.

In conclusion, using proper criteria, I believe that epididymitis should be treated as a bona fide occupational related injury.

References

1. Wesson, M.B.: Epididymitis, Facts and Fancies, Med. Clin. N. Amer. 43:1645-1659, 1959.
2. Wesson, M.B.: Epididymitis: Importance of Determining Etiology, J. Urol. 85:960-964, 1961.
3. Lewis, E.L. and Palmer, J.M.: Office Diagnosis of Epididymitis, Epididymo-orchitis and Orchitis, West. J. Med. 133:270-273, 1980.
4. Kohler, F.P.: Inquiry into the Etiology of Acute Epididymitis, J. Urol. 87: 918-922, 1962.
5. Andur, M.L.: Industrial Epididymitis and Epididymo-orchitis, Industrial Med. 12:371-373, 1943.
6. Hughes, E.C.: Discussion of Non-specific Epididymitis, Proc. Roy. Soc. Med. 36:323, 1943.
7. Mahony, J.D.H.; Harris, J.R.W., and McCann, J.S.: Acute Epididymitis, Brit. Med. J. 2:526, (May 29) 1971.

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Chest wall reconstruction after radiation necrosis

Issa F. Baroudi, M.D.

ABSTRACT: Radiation necrosis of the chest wall treated by radical surgical debridement is discussed along with successful reconstruction by means of latissimus dorsi myocutaneous flap.

This presentation demonstrates how myocutaneous flaps improve the quality of patient care and decrease hospital stay and cost when properly applied in the management of difficult wounds.

Case report • The 59-year-old white female underwent left modified radical mastectomy for infiltrating ductal carcinoma. Seven months later early recurrence was detected in the axilla which was managed by radiation, 6,000 rads, to the internal mammary chain and the axilla with 30 dose fractionation. Two months afterward a radiation ulcer developed accompanied by a severe foul smell, lymphedema of the left arm, brachial neuritis, and a frozen shoulder with severe underlying fibrosis. For eight months thereafter she was treated by repeated debridement, wound packing, and zinc oxide to the adjacent skin without good response. Occasional biopsies from the wound margins revealed no evidence of malignancy. She was readmitted to the hospital for whirlpool treatment, systemic antibiotics, and repeated evaluations which revealed no metastasis. Radical excision of the ulcer and wound coverage by means of latissimus dorsi myocutaneous flap was planned (Fig. 1) as recommended by the plastic surgery service.

Radical surgical debridement was performed with the patient under general anesthesia and the soft tissue defect was resurfaced by the flap (Fig. 2) after preservation of the neurovascular pedicle-thoraco-dorsal nerve and artery. The flap was rotated and secured in place with a subcuticular closure of 3-0 Dexon sutures over a large closed-type drainage system (Fig. 3). The donor site was closed primarily (Fig. 4). The patient's recovery was uneventful up to her recent office visit six months postoperatively (Fig. 5).

Discussion • Remarkable progress has been made in the reconstruction of soft tissue defects by means of muscles, myocutaneous and free microvascular flaps in the last ten years. Transfer of tissue safely without delay is a common practice especially with further understanding of skin blood supply, flaps, physiology and design.[1-3]

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Fig. 1. — Radiation ulcer, chest wall.



Fig. 3. — Rotated myocutaneous flap.



Fig. 4. — Primary closure of donor site.



Fig. 2. — Latissimus dorsi myocutaneous flap.



Fig. 5. — Rotated myocutaneous flap after six months.

The latissimus dorsi myocutaneous flap has a dominant blood supply provided by the thoraco-dorsal artery — a subscapular branch and the largest of the axillary arteries. This vascular pedicle is long enough to permit transposition along with bulk and minimal functional impairment, adding to its versatility in reconstruction of the chest wall or other parts of the body as a free flap. Other methods of reconstructing soft tissue defects by skin graft or local flaps have unacceptable poor results[2] in the presence of radiation injury — microvascular occlusion — to the soft tissues adjacent to the ulcerated area. In addition, there is fibrosis and direct cellular damage with chromosomal alteration, making cell replication more difficult and limiting its capacity in wound repair at the margin of the flaps or skin grafts.

During this patient's initial six months follow-up there was a remarkable decrease in the magnitude of pain and in the swelling of her left arm, along with increased mobility of the left shoulder and complete wound healing of the donor and recipient sites. The successful use of the flap eliminated prolonged, inconvenient and demanding patient care and spiritually supported a very depressed and debilitated patient irritated by the foul smell of her wound. Above all, it provided an answer to the question, "What is good for this patient to improve the quality of her life?"

References

1. Bostwick, J. III, et al: 60 Latissimus Dorsi Flaps, Plastic Reconstruct. Surg. 63:31, 1979.
2. Maxwell, M.D.: Myocutaneous Free Flap, Clin. Plastic Surg. 7:111-122, 1980.
3. Ross, R.: Complications of Surgery for Radiotherapy Skin Damage, Plastic Reconstru. Surg. 70:179, 1982.

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Detachable balloon occlusion of a giant intracranial aneurysm

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ABSTRACT: A 2 cm diameter wide-mouth aneurysm arising from the supraclinoid internal carotid artery was successfully occluded via transfemoral approach with a detachable balloon. The patient had subarachnoid hemorrhage and cerebral vasospasm-induced ischemia.

Ligation of the internal carotid artery is known to be useful for treatment of patients with large unapproachable aneurysms in the intracranial circulation, particularly carotid cavernous aneurysms and sometimes giant supraclinoid aneurysms. Recently, advances have been made with endoarterial placement of balloons, notably using the DeBrun technique,[1] in the therapy of these entities. We describe a case in which a silastic detachable balloon was used with good results.

Case report • A 44-year-old female was admitted to the hospital with sudden onset of slurred speech, headache, and weakness of the right arm and leg. Upon admission she was noted to have a right hemiparesis with decreased sensory findings as well as a right homonomous hemianopsia. Lumbar puncture revealed red blood cells in the spinal fluid consistent with subarachnoid hemorrhage. CT scan (Fig. 1) showed a large area of increased density in the suprasellar cistern which was interpreted as representing blood within a giant aneurysm and in the cistern indicating subarachnoid hemorrhage. A cerebral angiogram demonstrated spasm in the middle cerebral artery on the left. A large aneurysm (2 × 2 cm) was noted arising from the supraclinoid carotid in the region of the posterior communicating artery with no clearly definable neck. It had a somewhat irregular configuration with a slight bulge located posteriorly and medially and had considerable laminar flow within its lumen (Fig. 2).

Seven days later her condition became stable and the spasm was no longer present in the middle cerebral distribution as seen in the angiogram. The spasm had caused an infarct in the distribution of the middle cerebral artery. Later CT scans documented the infarct as an enhancing lesion in the middle cerebral distribution. Apparently the giant aneurysm had bled, causing the spasm, which in turn caused ischemia. Subsequently a 4-vessel angiogram failed to demonstrate any other aneurysms in the intracranial circulation.

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Fig. 1. — CT scan of the brain at time of admission shows blood density in the suprasellar cistern. One cannot tell whether blood is entirely within the giant aneurysm or in the subarachnoid spaces.

The patient continued to have dense hemiparesis on the right and homonomous hemianopsia attributed to the infarct. The hemianopsia could also have been caused by the mass of the aneurysm impinging upon optic radiations. In the complete angiography a cross-compression study demonstrated good filling of the left anterior and middle cerebral territories via the right carotid via a patent anterior communicating artery. There was very little filling from the posterior cerebral through a posterior communicating artery.

Because of the wide mouth of the aneurysm and the location, it was elected to attempt complete occlusion of the internal carotid with a detachable balloon rather than direct surgical approach. Since there was good filling of the middle cerebral territory on the left from the right side, it was believed this would provide adequate blood supply to the left hemisphere. The patient already had a dense hemiparesis on the right and was at less risk for occlusion of the carotid than someone with no deficit. Risks involved completely occluding the anterior choroidal and the posterior communicating arteries at their origins from the supraclinoid carotid. Also because of the location of the aneurysm's neck, which was unclear even on multiple views, there was a possibility that the ophthalmic artery might have to be occluded on the left causing, perhaps, complete blindness in the left eye. The patient was informed of these problems and agreed to arterial occlusion. This was performed via the right transfemoral approach.

A Becton-Dickinson sylastic balloon 1 mm in diameter initially was delivered into the supraclinoid carotid and inflated for ten minutes occluding the flow without being detached. There was no change in clinical signs or symptoms and the patient remained alert. Therefore, the balloon was detached in the anterior portion of the cavernous carotid and extended upward to about 5 mm above the clinoid. Several distal sites were tried but the aneurysm continued to fill on test injections. It was believed that the mouth of the aneurysm was even wider than originally appreciated. The balloon was filled with an isotonic concentration of contrast material and detached without neurological sequelae. The patient reported some pain in the left retro-orbital area which was attributed to balloon stretching of the intracavernous carotid stimulating the dura with its neural inervation. The ophthalmic artery was occluded on follow-up angiogram three days



Fig. 2 — (Left) Anteroposterior and (right) lateral views of left internal carotid injection show the laminar flow within the large suprasellar aneurysm.

later (Fig. 3). There was a good choroid-retinal blush via the external carotid anastomosis on that same side. There was no filling of the aneurysm either from left or right carotid injections. Right carotid injection produced excellent filling of the left middle cerebral distribution vasculature.

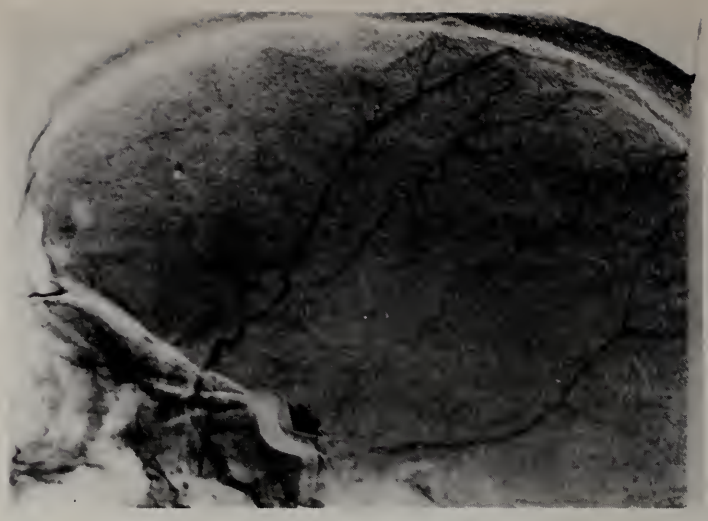


Fig. 3—Detached balloon with constant material within it completely (arrow) occludes suprasellar carotid in this post-embolization left carotid angiogram. A choroid-retinal blush is noted demonstrating flow to the retina via facial artery collaterals.

Discussion • With complete occlusion of the mouth, it is anticipated that the aneurysm will progress to thrombosis. Ultimately it will remain in place and have some mass effect but may decrease in size when the clot contracts in the normal course of events. DeBrun in 1981 reported nine cases of giant supraclinoid aneurysm treated in this manner.[2] Eight of these patients required complete occlusion of the supraclinoid carotid and all tolerated the procedure well.

Since very little diffusion takes place in the particular type of balloon used in our patient and since the contrast material is isotonic, it remains within the balloon for long periods of time, thus keeping it inflated until thrombosis can occur. Dr. Robert White noted that this type balloon remains inflated for as long as four years.

We consider the procedure a safe alternative to surgery in patients who demonstrate a patent Circle of Willis or who might receive a superficial temporal artery middle cerebral artery anastomosis beforehand.

References

1. DeBrun, G. M.: Balloon Catheter Techniques in Neuroradiology, in Interventional Radiology: Athanasoulis, C. A.; Pfister, R. C.; Green, R. E. and Roberson, G. H., W. B. Saunders Co., Philadelphia, 1982, p. 725.
2. DeBrun, G.; Fox, A.; Drake, C.; Peerless, S.; Girvin, J. and Ferguson, G.: Giant Unclippable Aneurysms, Treatment with Detachable Balloons, AJNR 2:167-173, 1981.

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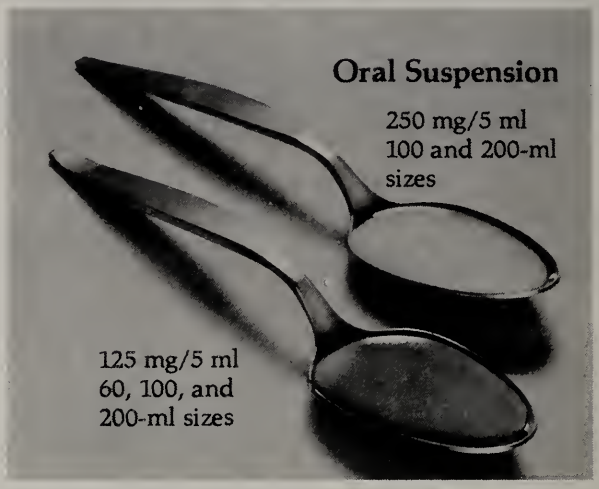
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SPECIAL ARTICLE

Formation of a statewide referral system for hemophiliacs: the Hemophilia Association of Florida

Clarence H. Brown III, M.D., Eva V. Hvizdala, M.D., Eric Lian, M.D., and Craig Kitchens, M.D.

Hemophilia, as defined in this paper, is the term used for a number of inherited plasma abnormalities which result in increased hemorrhage. There are several types; however, factor VIII deficiency and factor IX deficiency collectively make up approximately 85% of all hemophiliacs. As the incidence of hemophilia is roughly 1:10,000, we estimate that there are approximately 1,000 hemophiliacs in Florida. These patients presumably are randomly distributed throughout the state.

The last three decades have seen dramatic changes in the care of the hemophiliac. The "state of the art" care of hemophiliacs in the 1950's was essentially whole blood transfusion, the strict avoidance of surgery, less-than-optimal understanding of genetics, and usually a state of extreme conservatism in managing the patient which nearly bordered on forced invalidism. During the last 30 years, the various types of hemophilia have been delineated. We have a better understanding of the diagnosis, pathophysiology, and treatment of the vast majority of bleeding disorders. Cryoprepicitate and then commerically available factor concentrates have drastically improved the patient's life. For example, elective surgery is now feasible and presently hemophiliacs should enjoy the benefits of surgery and comprehensive dental care as well as anyone else. As hemophilic disorders have become clarified, carrier detection and genetic consultation have become feasible. Finally, the hemophiliac need not lead such a sheltered life. In fact, he can participate in most of life's daily activities which we otherwise take for granted.

In keeping with the trend of several chronic disorders which in general have a low incidence, there is a growing desire to establish a statewide referral network not only for medical consultation but for the needs of the hemophiliac as it pertains to his health, livelihood, and other rights as citizens of the state.

Background • There have been several attempts on the part of patients, their families, and medical professionals to organize hemophiliacs within their spheres of influence. This has not, to date, been done in a concerted coordinated manner and thus each attempt has been met with limited success. Another problem has been that when such efforts succeeded in the more densely populated areas, there have been limited benefits for the hemophiliac in less densely populated areas. Hemophiliacs are not as well identified or organized in Florida as they are in other states. Conversely, patients with other chronic diseases within this state are often well organized.

Through the slow but persistent effort of a few professional and lay persons interested in organization, there has come into being an amalgamation of

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parties interested in hemophilia and its impact on the patient and family. These smaller groups have confederated into a larger group having common needs and goals with few, if any, differences. Thus, the Hemophilia Association of Florida was created.

The purpose of this communication is to inform the practicing physician in Florida of this organization and its plans for advancing the cause of hemophilia. The resources of the organization are available to the physician or his patients through consultation. In no way should this be construed as an attempt to concentrate the care of all hemophiliacs to a small number of physicians. Rather, those physicians with a particular continued interest and expertise in this disorder and having at their disposal laboratory tools feel a need to promote this organization in order to benefit the care of the patient through consultation.

The resources of the organization are available to the physician or his patients through consultation.

Goals • The goals of the Hemophilia Association of Florida (HAF) are as follows:

1. To identify hemophiliacs who reside within the state of Florida and to have them known by diagnosis and name of their primary care physician.
2. To provide, through a collective group, a platform from which to seek and procure political and legislative assistance in correcting underlying problems in at least the following areas:
   A. Individual or group health insurance covering the hemophiliac and his family.
   B. Difficulties in obtaining and retaining employment.
   C. Areas of misunderstanding the public may have concerning hemophilia.
   D. Discrimination by third party payors with respect to outpatient purchasing and administration of factor concentrate as opposed to strictly inpatient services.
3. To publish and disseminate to members information of mutual interest by means of a newsletter.
4. To develop a group purchasing system for buying supplies and factor concentrate on a more competitive basis than is presently possible.
5. To develop and promote a comprehensive home care treatment program for patients and families who are so inclined and prepared.
6. To establish four comprehensive hemophilia centers available for consultative care on an as-needed-basis to assist the referring physician and his patients.
7. To enhance procurement of local, state and federal grants for the care of the hemophiliac and his family.
8. To establish a summer camp for younger hemophiliacs.

Organization • HAF was founded at a meeting held in Orlando at the Central Florida Blood Bank in September, 1983. Prime among the key forces toward this realization was the Florida Association of Blood Banks (FABB) and, in particular, the chairman of the Ad Hoc Hemophilia Committee, Col. Jim Glikes, Director of the Civitan Regional Blood Center in Gainesville. That meeting was attended by several lay and professional persons representing either themselves or their organizations. At that time, HAF was founded and bylaws, a charter, and articles of incorporation were established. Officers were elected. Col. Jim Glikes was elected President of the organization. Mr. Joseph H. Williams of Jacksonville was elected Vice-President, Ann Mendenhall of Gainesville was elected Secretary/Treasurer and Craig S. Kitchens, M.D. was elected Medical Director.

The state was divided into eight regions which follow lines of existing Health and Rehabilitative Services (HRS) districts. Each region has within it an FABB approved blood bank which has agreed to assist in implementing the goals as listed above, chief of which is the procurement and distribution of blood products used by the hemophiliac. Each region has within it a physician having an interest and knowledge of hemophilia who has agreed to serve as medical coordinator of that region. Additionally, a dedicated lay person within each region has been appointed to serve as lay coordinator.

Apart from the eight regions, we represent four hemophilia referral centers which can serve in a consultative capacity for persons anywhere in the state. Each of these centers is associated with one of the authors, each of whom has a primary and continued interest in both the care of hemophiliacs as well as research in that disease. Additionally, each referral center has identified a lay person as the contact person for that center.

Resources available • The following resources are available at this time in the four hemophilia referral centers:

- *Accurate identification of the exact nature of the hemophiliac's problem.* Hemophilia can result from congenital or acquired absence of any of the coagulation factors. Precise treatment depends on exactly which factor is affected and also to what degree that deficiency exists. Facilities are also available to determine the deficiency of the less commonly affected factors such as factors, II, V, VII, X, XI, XII and XIII.

- *Inhibitor screening.* Approximately 10% of hemophilia patients develop an inhibitor to the factor which they lack thereby greatly complicating treatment. We feel that hemophiliacs should be screened for the presence of an inhibitor approximately every year and particularly prior to elective surgery.
- *Genetic counseling.* By determining coagulant activity and antigen levels of hemophiliacs and their mothers and sisters, quite accurate carrier detection can be made by laboratory means. Obviously, genetic counseling hinges upon the ability to make these determinations.
- *Centers for elective surgery for hemophiliacs.* Generally, it is advisable to perform elective or other surgery on a patient only after his hemorrhagic disorders have been thoroughly characterized, the presence of an inhibitor excluded, psychological motivation evaluated, and surgical indications established. Additionally, it is out belief that elective surgery should be accompanied by accurate and repeated determinations of factor levels to adequately monitor and facilitate factor replacement therapy to assist the surgeon in providing adequate hemostasis.
- *Assistance in managing patients with inhibitors.* Patients with inhibitors represent unique therapeutic problems. The collective experience in dealing with these patients gives these centers a broader perspective in the management of such patients.
- *Facilitation of home care therapy.* Resources are available to assist the patient and his family in determing proper motivation and understanding for beginning an individualized home therapy program. This method of treatment clearly has been shown to decrease the cost of overall care of the hemophiliac and to decrease greatly both time in the hospital and time missed from either work or school.
- *Preventive therapy directed to avoid or at least diminish crippling arthropathy.* Early detection and use of non-surgical means (braces, intensive physical therapy with short-term use of prophylactic factor concentration) can prevent this major cause of crippling disease in hemophiliacs.
- *Dental check-up and oral hygiene counseling.* Preventive aspects of dental care will greatly improve overall dental health of the hemophiliac.

Funding ● At the present time, this organization has no intramural or extramural funding. Payment for consultation will continue to depend upon traditional payment for such services rendered through Childrens Medical Services (CMS), insurance, other third party payors, or private funds. A limited number of patients can be seen free of charge if they are unable to pay. It is hoped that the state and lay organizations will eventually provide enough money to meet most of those costs and collectively, enough to help defray the cost of factor procurement.

Since two of the authors have appointments with Veterans Administration Medical Centers, a referral system for veterans would be available.

Of prime importance in this early organizational phase of HAF is accurate identification of all hemophiliacs residing within Florida.

Summary ● At this time, there is a lay and professional group within the state, The Hemophilia Association of Florida, which is designed to serve many medical and social needs of the hemophiliac. These resources are available to the practicing physician and any of his patients. It is hoped that this information will be passed along to any patients with hemophilia or other inherited disorders of coagulation under a physician's care in Florida. Of prime importance in this early organizational phase of HAF is accurate identification of all hemophiliacs residing within Florida. Should you or one of your patients have interest in this group, please contact one of the individuals listed below.

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FMA Committee on Impaired Physicians

References:

1. Stone PH, Turi ZG, Muller JE. Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104 672-681, September 1982
2. Antman E, Muller J, Goldberg S, et al. Nifedipine therapy for coronary-artery spasm. Experience in 127 patients. *N Engl J Med* 302 1269-1273, June 5, 1980

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PRDCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates. PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis. Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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NOTES & NEWS

Dr. Parham honored by AMA

W. Harold Parham, D.H.A., Executive Vice President of the Florida Medical Association received a special commendation resolution before the American Medical Association House of Delegates in December. The resolution honored Dr. Parham's 35 years of dedicated service to the profession. It stated that the House of Delegates ". . . gratefully acknowledge medicine's indebtedness to this dedicated, devoted, energetic and talented friend of medicine who for thirty-five years has toiled tirelessly on behalf of the great profession which has adopted him and which he so dearly loves." Dr. Parham will retire from the Florida Medical Association in April 1984.

Dr. Coleman reappointed by President Reagan to Blood of Regents at USUHS

Francis C. Coleman, M.D., a nationally known pathologist, was recently reappointed by President Reagan and confirmed by the U.S. Senate to a second six-year term on the Board of Regents of the Uniformed Services University of the Health Sciences (USUHS), Jay P. Sanford, M.D., President and Dean of the University, has announced.

Dr. Coleman, who is currently in private practice in Tampa, Florida, is a Life Fellow of the College of American Pathologists and a Life Trustee of the American Board of Pathology. He is a recipient of many professional awards, including the American Society of Clinical Pathologists and the College of American Pathologists' Distinguished Service Award.

Dr. Coleman is currently president-elect of the Florida Medical Association. He will take office in May, 1984.

The Uniformed Services University, which was created by Congress in 1972, prepares men and women for careers as medical officers in the uniformed services of the Army, Navy, and Air Force.

Dr. Hodes receives Dr. Benjamin Rush Award

Former president of the Florida Medical Association, Richard S. Hodes, M.D., of Tampa was one of two recipients of the American Medical Association 1983 Dr. Benjamin Rush Award for Citizenship and Community Service. The award was presented before the AMA House of Delegates at its December interim meeting in Los Angeles. Dr. Hodes is a former member of the Florida House of Representatives and currently is Professor and Chairman of the Department of Anesthesiology at the University of South Florida College of Medicine. The other recipient of the Rush Award was Samuel R. Sherman, M.D., of San Francisco.

Dr. John Cheleden, former Judicial Council Chairman dies

John Cheleden, M.D., of Ormond Beach died on November 9, 1983 during a trip to Philadelphia to accompany his ailing wife. Dr. Cheleden was 75.

Dr. Cheleden had an illustrious career with the Florida Medical Association having served as Chairman of the Judicial Council for six years. He did such an outstanding job he became known as Judge Cheleden to his colleagues. Between 1967 and 1972 he also served as a member of the Florida Board of Medical Examiners. The Florida Medical Association accorded him with two awards: the Certificate of Merit in 1972, the highest accolade given annually to an outstanding member; and the Certificate of Recognition in 1978, given in appreciation of his leadership and achievements as Chairman of the Judicial Council.

Dr. Cheleden was a graduate of Gettysburg College of Medicine and Jefferson Medical School. In his honor, the medical staff at the Halifax Hospital Medical Center has established a John Cheleden Memorial Cancer Fund and has named its GI laboratory after him.

President Reagan calls for voluntary blood donors

President Ronald Reagan has designated January as National Voluntary Blood Donor Month to thank the volunteer blood donors of America, it was announced by William V. Miller, M.D., president of the American Blood Commission (ABC).

A national forum and coordinating group, ABC represents the major blood collection agencies as well as the medical, business and health communities, blood donors and patients to build a more efficient national blood program.

In his proclamation, the President commended both donors and blood banking: "Our blood banking service is the finest in the world and, through participation in the volunteer blood program, blood donors unselfishly share the blessing of good health with those who are less fortunate."

Each day nearly 37,000 units of blood or specialized blood components are transfused. Most Americans, at least 95% of those who reach age 72, will need blood during their lifetime.

Furthermore, the need for blood is increasing with rapid advances in medical science; such as, liver transplantation as well as the repair of damaged hearts.

"Also consider the everyday use of blood in hospitals to treat the sick, injured and burned," commented ABC's President Dr. Miller. "It's estimated that almost half of the American population is medically eligible to give blood. But less than 10% of eligible donors actually give. That's only four percent of the population."

President Reagan added, "I commend to all Americans this wonderful tradition of giving that benefits us all and remind you that the need for blood continues throughout the year."

ACP issues statement on drug therapy for pain in terminal illness

In order to preserve productive, pain-free lives for terminally ill patients, physicians must be knowledgeable about pain and the use of narcotics in pain therapy, the American College of Physicians (ACP) states in the December *Annals of Internal Medicine*.

Pain is one of the most common complaints physicians must deal with. While mild and acute pain are relatively easy to treat, the severe, chronic pain that accompanies terminal illness is not. Many of the effective analgesics cause side effects, and the pain itself can contribute to serious emotional and behavioral changes in the patient. For the terminally ill patient, this pain often is the only complaint the physician can treat. With this in mind, the ACP makes the following recommendations and encourages all physicians to learn how best to treat the severe, chronic pain of terminal illness.

The goal of drug therapy for severe, chronic pain in terminal illness is to make the patient relatively pain-free. In cases of terminal illness, the ACP contends that sufficient management of pain is more appropriate than aggressive attempts to cure the disease. Both the patient's short-term prognosis and the immediate effects of therapy should be considered in order to free the patient from pain while preserving a maximum level of function.

Oral administration of narcotics (e.g. morphine, methadone) on a regular basis will provide most terminally ill patients with relief from severe, chronic pain and from fear of that pain recurring. The College notes that pain in terminal illness is in general poorly managed due to incomplete knowledge or misuse of what is known. The physician must remain flexible, the ACP maintains, and adjust narcotic dosage, route, and frequency of administration to the needs of the patient.

The ACP further states that **there is no clinical evidence that the availability of heroin will improve the drug therapy provided for the severe, chronic pain of terminal illness.** The narcotics currently available to the physician are sufficient when given properly to provide terminally ill patients with relief from severe, chronic pain. Drugs such as aspirin and acetominophen may be used in combination with narcotics to enhance relief and to reduce the doses required for effective pain control.

Fear that patients will become dependent on the drugs has limited the effective use of morphine and other narcotics. The ACP posits that such a fear is unfounded, as dependence is of little consequence in the context of terminal illness. Studies show a marked lack of narcotics abuse in cancer patients, and indicate that a variety of conditions other than drug use alone are contributing factors to addiction. The College thus feels that it is important that narcotics be administered according to each patient's need, and that patients have access to necessary therapeutic narcotics.

The ACP accepts its responsibility to improve the internist's knowledge of narcotic therapeutics and drug therapy for severe, chronic pain in terminal illness. Physicians must be knowledgeable about pain — it causes, complications, and treatments — in order that terminally ill patients might live the remainder of their lives as productively as possible, says the College.

The ACP supports expanded research in the field of narcotic therapeutics. Though much has been learned about the causes of pain and the most effective ways to manage it, there is much that is yet unknown. Guidelines of care are best based on controlled observations of

therapies; thus, the College concludes, continued research is needed about both new and conventional treatments.

Complete copies of this and other ACP statements may be obtained from the Division of Public and Professional Communications.

The American College of Physicians, through rigorous membership requirements, contact with the private sector, and continuing medical education programs, has worked since its founding in 1915 to upgrade the quality of medical care, education and research in the United States. The medical specialty represents 57,000 specialists in internal medicine, related nonsurgical specialists, and physicians-in-training.

DEAN'S MESSAGE

On medical education

As we enter a New Year, it is refreshing to note that medical school curricula are coming under careful scrutiny once again. Furthermore, this review is being instigated by the medical schools themselves via an initiative of the Association of American Medical Colleges.

Unlike the curricular gyrations that occurred in the late 1960s and early 1970s, there are no Federal funds associated.

A genuine concern exists among the public, full-time practitioners and faculties over the quality of the medical education experience. The experimental methodologies of the 1970s, such as reducing the engorged four-year curriculum into three years, are not of great interest today. However, the actual delivery of didactic and experiential material is being evaluated in depth.

At the University of Florida College of Medicine, a broadly-based faculty, full-time practitioners, alumni, and student force is reviewing our curriculum, under the auspices of the Office of the Dean and the Curriculum Committee, chaired by Charles P. Gibbs, M.D. Each lecture, laboratory, clinical rotation, and small group discussion is being reviewed by a basic scientist, clinician, and student. While much that is being done in medical education is excellent, this Task Force is searching for better ways to convey the voluminous amounts of scientific information to medical students. Excellence in teaching and role modelling are being evaluated.

The Association of American Medical Colleges' Task Force on the General Professional Education of the Physician began its work approximately two and one-half years ago, and the final report will be available in the Fall of 1984. It has systematically reviewed the premedical years, as well as the experience of medical school. What will be their final recommendations? No one knows as of this date. However, it is safe to say that a major emphasis on the qualitative and humanistic values required of medical care will be important.

While the scientific basis of medical care is broadening at an enormous rate, and the medical schools have done and are doing a superb job of conveying this information, medical schools have not adequately emphasized the humanistic skills requisite of a physician. Ethics, history, and medical sociology are vitally important topics that should be included in each medical school's curriculum.

A rational revolution in medical education is at our doorstep. If we are to maintain and improve the quality of medical care, then our young people in the pursuit of a medical education must receive the very best instruction — scientifically and ethically.

Sir William Osler once wrote, "The physician needs a clear head and a kind heart . . ."

William B. Deal, M.D.
Dean, College of Medicine
Associate Vice President
for Clinical Affairs
University of Florida
Gainesville.

WORTH REPEATING

Rheumatic fever program in Florida

Almost ten years have elapsed since the formation of the Task Force on Rheumatic Fever. Currently chaired by Dr. Robert E. Windom, Immediate Past President of the Florida Medical Association, the membership of the Task Force includes representatives designated by the Florida Medical Association, the American Heart Association (Florida Affiliate), and the Department of Health and Rehabilitative Services, including representation from the program offices of Health and Children's Medical Services. Over the period of its existence, this body has directed its efforts towards programs that have sought to bring awareness to physicians, other health professionals and the public about the prevalence of Rheumatic Fever and Rheumatic Heart Disease in

the state of Florida. In addition, it has worked in refining and updating the registry for this disease. Through this action, the state was able to provide more effective services to those individuals who are victims of this disease and to the physicians who care for these patients.

Contrary to some anecdotal comments, rheumatic fever and rheumatic heart disease have not been eradicated in this state or in any other state. This year, 1,097 patients are on the rolls of the Florida Rheumatic Fever Registry. Last year, 97 new cases of rheumatic fever were added to this registry. How does this compare to ten years ago? When the Task Force convened for the first time, the number of patients on the registry was in excess of 2,500 while the number of new patients enrolled that year exceeded 200. Both of these figures undoubtedly represent only a fraction of the actual cases of Rheumatic Fever in the state of Florida. The more compelling information relates to the number of individuals who had cardiac valve replacement and whose surgery was sponsored by the Department of Health Rehabilitative Services. In 1975/1976, of the 39 individuals who had valve replacement, 22 had rheumatic valvular disease. In 1979/1980, 37 individuals were sponsored for valvular replacement; 16 of these patients had valvular disease secondary to rheumatic fever.

The decreasing number of patients seen over the past decade in this state who are registered with rheumatic fever and of patients undergoing surgery for rheumatic heart disease would support the impression that the incidence of rheumatic fever is declining. The question arises as to what has brought this about. Undoubtedly, many factors are involved in this decline, as well as in the overall decline in the incidence of rheumatic fever in the Western world. However, an additional bit of information may raise some interesting conjectures. If one examines the statistics for registered cases and for new cases of rheumatic fever in Florida during the decade preceding 1975, the numbers in these categories show little (if any) decrease. This fact suggests that an event occurred in the early seventies, an event that had a marked influence on the subsequent incidence of this disease.

Has the Florida Task Force on Rheumatic Fever and Rheumatic Heart Disease contributed to these changes? Two activities undertaken under the auspices of the Task Force can be invoked as having contributed significantly to the observed decline of rheumatic fever in our state. The first is the educational effort directed at the public through the information media. Through short informational messages aired on radio and television statewide and presented continuously for several years, the important role of "strep throats" in causing rheumatic fever and the importance of proper management of "strep throat" by the physician as a first step in preventing rheumatic fever were emphasized.

The second activity, while not contributing to the actual decline, was important in reducing the number of patients entered on the registry. The Task Force offered its services to physicians to review the records of patients whose diagnosis was in question. Through this review process, many patients were removed from the registry. This "delabelling" meant a return to normal life to the individual, eliminated the need for constant prophylaxis and thus added relief to the state from expending its resources unnecessarily.

Another service that has contributed to this decline is the offering, at no cost, of streptococcal antibody tests to physicians through a grant to the American Heart Association. The utilization of these tests has further helped in allowing the proper identification of patients with acute rheumatic fever and rheumatic heart disease, and helped avert the initial misdiagnosis and mislabelling of patients with a suspicious presentation of signs and symptoms suggesting rheumatic fever.

In addition to these accomplishments in the areas of primary diagnosis and prevention, the Task Force has expended efforts towards achieving a more effective program for secondary prophylaxis. To prevent recurrences of rheumatic fever, the offering of antibiotic prophylaxis at no charge at County Health Units has been coordinated with the computerized registry. A more efficient distribution of these antibiotics has thus been achieved. To assure compliance by those who should be taking antibiotics, a program of testing urine for penicillin was instituted. This service is available to all patients and physicians. Data procured through these tests indicate that the rate of compliance has risen steadily over the past four years. The initial compliance rate, as assessed by the percentage of patients whose urine is tested and found positive, was close to 60%, a rate below the national average. This percentage rose to 65% in 1980, 79% in 1981 and 82% in 1982. The most recent figures for 1983 show a compliance rate of 86%, a figure significantly higher than the current national average.

Florida and its physicians can be proud of the progress they have achieved in this area. These achievements have been enhanced by a Task Force that had recourse to a combination of talents and resources from the State Government (HRS), the State Medical Association (FMA) and one of the State Voluntary Health Associations, the American Heart Association, Florida Affiliate which, through special allocations, funded the expenses of one of the above activities and the expenses of the Task Force Members. The challenge to continue in this path of prog-

ress is still there. Additional challenges face us. These include the education and the provision of care to newer populations that have joined us and who are at greater risk for succumbing to this disease. Yet the greatest challenge that we face is but one — that of the eventual eradication of a disease that can be prevented, one that strikes at the hearts of our children during the most critical phase of their formative years.

Task Force Members

Robert E. Windom, M.D., F.A.C.P., F.A.C.C., Chm.

Elia M. Ayoub, M.D.
David A. Cimino, M.D.
S. D. Doff, M.D.
Elbert C. Hartwig Jr., Sc.D., M.P.H.
Jack H. Hutto, M.D.
Alfred E. Ogden, M.D.
F. Edwards Rushton, M.D.
Dolores F. Tamer, M.D.
John Witcomb, M.D.
James White, M.D.

Ex-Officio Consultants
Mary Ann Datz, R.N.
Mr. Jay R. Francis
Stephen H. King, M.D.

Resource Advisors
William W. Ausbon, M.D.
Carroll G. Bennett Jr., D.D.S.

AHA/FA Staff Consultant
Miss Mary A. Nowakowski
Gerold L. Schiebler, M.D.

Reprinted with permission from *The Florida Pediatric Society Newsletter*, Vol. V., No. 3, December 1983

The age of medical competition

Until recently, all a physician had to do to be successful was to open his doors to practice, and then to practice to a degree on a par with other practitioners in the community.

Once the physician establised his practice, there was little concern about losing patients to other colleagues, or to other forms of health care delivery. More importantly, the absence of certain judicial and legislative regulations allowed the physician to concentrate his efforts on the practice of medicine, rather than on conditions that would force him to employ ways to maintain his practice.

Those days are gone forever, replaced by the emergence of a new age of competition in the health care industry which is changing the way medicine is now being practiced. While some are in favor of what they consider to be a more open marketplace, others are looking at this phenomenon as a direct and personal threat.

Competition in health care has come about for a number of reasons. First, the number of physicians is increasing at a rate that's outpacing the number of patients available. The Graduate Medical Education National Advisory Committee (GMENAC), which was commissioned to do a study on patterns of physician growth, reported that we are on the verge of a physician surplus, particularly in certain highly trained areas of specialization. Many medical schools, because of their state and federal subsidies are tied to student capitation, continue to generate large numbers of graduates. Training less students per class would lead to correspondingly lower reimbursement and intolerable strains on their budgets.

Second, the influx of foreign trained physicians, most of them American citizens who, by choice or design, were trained outside the United States, has added to the burgeoning physician population.

Another reason for increased competition in health care involves third party payors — the federal government and private insurors. In an effort to contain the costs of medical care, or bring them down, third party payors are primarily responsible for experimenting with alternative health care delivery mechanisms. Dade County has been selected as the testing ground for one of these systems — the health care maintenance organization (HMO).

Under what has been termed a "demonstration project," certain HMOs in Dade County have been allowed to enter into contracts with the federal government. This arrangement lets the HMOs deliver to their enrollees a total package of medical (and dental) care at a per capita reimbursement that is lower than the average payout per Medicare beneficiary last year. These federally subsidized HMOs are permitted to waive the Medicare deductible and co-insurance features — something which the private physician is not allowed to do. Some call this unfair competition.

Finally, competition has also been spurred by the Federal Trade Commission ruling that allows physicians to advertise their services. The FTC saw this as a way to promote competition among physicians and thereby lower patient costs.

It is the combination of these factors that has placed the physician in a new (and albeit sometimes uncomfortable) role. In addition to concerns about family and patients, the physician now finds himself looking for innovative ways to earn a livelihood. With more doctors and less patients, the dilemma becomes more imposing and the choices less appealing.

Should he just opt for a smaller piece of the pie; that is, a lower income? Should he try to practice "fringe" medicine which allows him to maintain an income be fostering unnecessary care upon his patients? Should he join an HMO, or seek a full-time administrative position? Or should he worry less about competition and more about his ability to deliver competent, individualized care to his patients?

Whatever choices are made, it must be kept uppermost in mind that you can't fool all of the people all of the time. The American people have historically indicated their desire to stay with excellence, and the cream usually rises to the top.

A sincere and dedicated physician, one who is truly concerned about his patient's welfare, and who delivers personalized, compassionate care, will do well in any setting. Your medical association stands ready to see that the game is played fairly, and will fight to ensure that the best care available is offered to patients at a price they can afford.

Granted, a threat may be there, but it's not as awesome as some may believe. Politicians say an informed electorate votes with their feet. The DCMA will do its part to help keep the electorate informed, and standing.

Charles A. Dunn, M.D.

Reprinted with permission from Miami Medicine, January 1983.

The delivery of health care. . . take an offensive approach

Practicing physicians need and should play a greater role in the development or formulation of policy regarding the practice of medicine. Unfortunately, the number of physicians involved in the formulation of these policies are relatively small, and a significant number of these physicians are not practicing medicine. This fact plus the input of lay people representing the governmental agencies, both state and federal, compounds the problem.

The attitude of a significant number of the practicing physicians who do not care to become involved is one of apathy in some cases, and frustration and futility in others. These attitudes have to be overcome, and this can best be done by the local, regional and national medical societies. In the case of apathy, the medical societies have to find a way to communicate with the group (practicing physicians) and to impress upon them the need to become involved in policy decisions. These decisions will play a significant role in the manner that physicians will earn their livelihood. The importance of the practicing physicians input in the formulation of policies cannot be overstressed, and the considerations of their ideas and recommendations is paramount since this is the group that will have to carry out the formulated regulations and policies.

The attitude of frustration and futility is and will be very difficult to overcome. It is apparent that the medical profession will have to revise its approach to the formulation of policies regarding the delivery of health care. The medical profession's approach for the most part has been depressive in that they only react to proposed changes in medical policy. The attitude of futility and frustration has largely grown from the fact that undesirable changes have been brought about in spite of this opposition and in some cases inability to have its views adequately voiced.

In order to obtain more fruitful results in the formulation of medical policies, there are two important avenues to be pursued: (1) Give or make views known and suggest solutions to the problems that affect the nation's health or the health care delivery system. In short, take an offensive approach. (2) The medical profession should and will have to become more involved in politics in order to be more influential in the legislative process. The potential political strength of the medical profession has never been utilized and in most instances not even realized. The greater portion of the voting population and practically all of the legislators and elected officials have their own private physician whom they hold in high esteem. In view of this relationship, the medical profession should have the greatest influence on the legislative process when compared with any and all other groups. The medical societies should become cognizant of the private physician of each and every legislator and elected official and maintain close communication with these physicians in order to keep them apprised of the issues and the views or direction that the medical profession should pursue. This group of physicians can then exert their influence on their respective legislator and in this manner play an active role in the formulation of medical policies and make a significant contribution to the medical profession.

The state and national medical societies or their political arm should monitor legislation regarding health issues and maintain a log indicating the vote and view of each legislator and elected official on such health issues. This information should be passed on to the members of the society periodically, especially prior to elections.

The approaches as mentioned above should significantly increase the participation, influence, and numbers of practicing physicians at the policy-making level.

Ronald T. Smoot, M.D.
President, Medical
and Chirugical Faculty
of the State of Maryland

Reprinted with permission from *The Bulleton of The Polk County Medical Association*, Vol. 24, No. 3, March 1983.

Staying Back: Another Year in the Same Grade

By Janice Hale Hobby with Gabrielle and Daniel Rubin, 93 Pages. Price $6.95. Triad Publishing Co.

Some time ago, eight-year-old Matthew Reimer, a Gainesville youngster was asked to repeat the second grade. He became at first understandably upset. The extra year, however, gave him a chance to mature physically and emotionally (he was one of the youngest children in the class), and he did very well.

He then wrote and illustrated with pictures of striking vitality a 10 page book recounting the highlights of his experience. Believing his story might help other children in similar straits, Matthew's parents brought it to the attention of Lorna Rubin, a local publisher and wife of the Chairman of Ophthalmology at the University of Florida College of Medicine. In fact the publishing house had started by bringing out Dr. Melvin L. Rubin's excellent textbooks in his specialty.

From first grader Billy (no real names are used in the book other than that of his genial originator) to Ronald James Hobson III, a multiplicity of reasons explaining why a child may be held back are teased out and illuminated. How a youngster can not only survive, but actually profit from such an event is candidly spelled out.

Children mature at different rates, of course, independently to some extent from rigid chronological landmarks, but our school system can make only limited allowance for that fact. A serious medical illness can hold a youngster's performance down; so can a physical handicap, such as deafness. Poor eyesight, dyslexia, family turmoil, even moving from one part of the country to another, can highly impact on school adjustment.

In 1980 3.5 million children in the United States, 17 percent of all students, were enrolled below their modal grade level because they had been held back some time during their schooling.

In the 1930's grade retention was widely discouraged and the practice of "socially promoting" students became acceptable. During the early 70's the tide reversed, due to declining achievement rates: standard assessment tests are now enforced in 38 states, including Florida.

"Parents now insist that their children be accountable for their school work," declares Dr. William Pierce, from the Council of Chief State School Officers. "As a result, there will be more grade repetition . . ."

School psychologists rate as severe the stress suffered by children undergoing this type of crisis, and they argue for limits to this trend.

This book takes no sides on the issue; its purpose is rather to help children caught in this dilemma, by offering appropriate models of youngsters who are not only able to cope efficiently with the problem, but for whom it becomes a significant growth experience.

This is a book that may be placed profitably in the waiting room of any pediatrician, child psychiatrist or family physician. Sensitive illustrations by Daytona Beach water colorist Carol Richardson enrich this slim volume, as does a well thought out "Message to Parents," by psychologist Barry M. Dynn, Ph.D.

Jose J. Llinas, M.D.
Gainesville

● Dr. Llinas is in private practice of psychiatry in Gainesville, where he is also Clinical Professor of Psychiatry and Family Practice at the University of Florida College of Medicine.

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AIR FORCE

A great way of life.

Auxiliary Liaison Editor — **Mrs. L. G. (Mae) White**

"G.O.L.D.," Silver Stars and S.A.S.

The Florida Medical Association Auxiliary's membership team is hard at work helping Florida move up from number 2 position in national membership to the number 1 position. The District Vice-Presidents: Jane Eberly, Barbara Freeman, Phyllis Hansard, Margaret Vizzi, Beebe White and Sandy Whittaker are visiting, writing and calling each county in their districts to encourage participation in our membership efforts.

In addition to our regular member campaign, there are many other areas of membership which are very important and necessary in order to strengthen our auxiliary. Ken Nelson from Winter Haven is the first state Male Spouse Chairman. In addition to his job with a public relations firm, he is finding time for auxiliary involvement. Ken will be promoting his slogan "G.O.L.D.," which stands for "Gents of Lady Doctors." He is in the process of contacting all of the spouses of female physicians in Florida regarding his program.

This year the Auxiliary is recognizing a new group from our midst, the "Silver Stars." These are auxilians who have belonged to the auxiliary 25 years or longer. Local auxiliaries are planning special events to honor these members who will also be honored at the annual meeting in May.

Another special group, the Resident Physician/ Medical Student Spouses, are our key to the future. We must convince these young people of the importance of belonging to our group that has had and will have a great deal with molding the future of medicine in our country. The Auxiliary is involved in helping RP/MSS groups at all of the medical schools in Florida with Auxilians serving as advisors, offering their homes for meetings and helping with programs. Along with the Florida Medical Association, the Auxiliary feels a strong need to involve this young, viable group in our organization. Realizing that for many of these young people, funds for dues to organizations such as ours are often non-existent; the Auxiliary has instituted a program called "SPONSOR-A-SPOUSE" (S.A.S.). Last year we sponsored 350 spouses for membership in the American Medical Association Auxiliary. This year we would like to double that number. With your help, this will be possible.

How to help??? The cost is $5.00 per RP/MSS sponsored. You may sponsor as many as you choose. It is tax deductible. You will receive the name or names of those you have sponsored. To sponsor: Send check payable to FMA-A — RP/MSS. The deadline is March 1, 1984. Send to:

Mrs. Milton Tignor
901 Country Club Drive
North Palm Beach, FL 33408

Seminole County's Carmen Dominquez is the Foreign-born Spouse Chairman. The Auxiliary is encouraging the participation of this large segment of our membership. Many counties are planning international teas, luncheons or dinners where the foreign-born spouses help with the food preparations. Special interest groups conduct classes in foreign languages and also teach English to the foreign-born with auxilians as instructors. Mainly, the Auxiliary is interested in seeing that our friends and auxilians from other lands are made to feel welcome and that they become contributing members of our organization.

At the national level, our membership team is faced with a challenge from the state of Ohio to an Increase-Your-Membership battle. The state with the greatest percentage increase in members this year will be the winner, and Florida is well on the way.

"EACH ONE REACH ONE," the Florida Medical Association Auxiliary's membership slogan, sums up the membership plans and programs for the year.

Mrs. Milton (Jo) Tignor
Membership Chairman
North Palm Beach

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Director, Interventional Cardiovascular Medicine
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Summary of the FMA Board of Governors Meeting January 14, 1984

The following is a summary of the major actions taken by the Board of Governors at its meeting January 14, 1984:

THE BOARD:

HOSPITAL MEDICAL STAFF SECTION

Approved the establishment of an Ad Hoc Committee of the Board to consider the feasibility of establishing a section or other appropriate mechanism for hospital medical staff input to the FMA and requested the Committee to submit its recommendations to the Board at its meeting in March.

NATIONAL KEY CONTACT PHYSICIANS

Approved appointment of FMA national key contact physicians for 1984 for Florida's 19 congressional districts and two U.S. Senators.

***FMA JOURNAL* EDITOR**

Enthusiastically approved the President-Elect's nomination of Daniel B. Nunn, M.D., of Jacksonville for reappointment as Editor of *The Journal of the Florida Medical Association, Inc.*, for 1984-85.

FLAMPAC BOARD OF DIRECTORS

Approved appointments to the FLAMPAC Board of Directors in accordance with the newly amended Bylaws of FLAMPAC.

At its meeting in October 1983, the Board approved a modification to the FLAMPAC Bylaws to allow for an expansion of the Board of Directors to 34 members, the majority of which shall be physician members of the FMA.

FPIR LIAISON COMMITTEE

Approved the appointment of the following physicians to the Liaison Committee to the Florida Physicians' Insurance Reciprocal (FPIR) in accordance with Substitute Resolution 83-20 adopted by the House of Delegates at its meeting in May 1983:

Robert E. McCammon, M.D., Chm.,
Obstetrics/Gynecology, Tampa
William W. Thompson, M.D.,
Pediatric Allergy, Ft. Walton Beach
James F. Cooney, M.D.,
Neurosurgery, West Palm Beach
H. Quillian Jones Jr., M.D.,
General Surgery, Ft. Myers
Jimmie Dale Moore, M.D.,
Anesthesiology, Orlando

PREPAID HEALTH PLANS

Requested the Council on Medical Economics to conduct an immediate review of the marketing and operation of prepaid health care delivery programs, including PPOs in Florida and submit a report to the Board at its March Meeting.

FMA INSURANCE PROGRAMS

Approved FMA sponsorship of the E. F. Hutton Financial Management Services Program, which includes investment and money management services. The Program will be marketed through PIMCO to members of the FMA.

COUNCIL AND COMMITTEE REPORTS

AMA DELEGATES

Received as information the report of the Florida Delegation to the AMA regarding the actions of the AMA House of Delegates at its Interim Meeting, December 4-7, 1983.

Florida Resolutions

The Florida Delegation introduced three resolutions at the Interim Meeting.

AMA Resolution of Commendation of W. Harold Parham, D.H.A.

The AMA House of Delegates at its First Session honored Dr. Parham, who retires from FMA on April 1, 1984, and adopted a resolution acknowledging medicine's indebtedness to Dr. Parham for his dedication, devotion, energy and talents, and for his tireless efforts in behalf of medicine for 35 years.

Resolution 19 - Patient Medication Instruction (PMI) Sheets

Resolution 19, which was not passed by the House, recommended that the AMA promote the use of the PMI sheets by pharmacists to increase the availability of drug use information for the public.

Resolution 20 - "Opium" Perfume

This resolution passed by the House called for the AMA to notify the management of E. R. Squibb and Sons, Inc., of its strong objection to the advertising campaign for "Opium" perfume, and further that the AMA express strong objection to the management of Pippo, Inc., over its "Stash" advertising campaign, The House of Dinard Perfume Laboratory for the "Sinsemalla" advertising campaign and Cocaine International for the "Cocaine" advertising campaign.

JCAH Standards for Hospital Medical Staffs

The Florida Delegation introduced an amendment to the Report of Reference Committee D regarding AMA policy on standards for hospital medical staff privileges. The Florida amendment called for limiting the definition of the hospital medical staff to medical doctors, doctors of osteopathy and doctors of dental surgery. Limited practitioners would be granted hospital privileges within the scope of their licenses, and in accordance with state law and existing hospital standards. The Florida amendment was consistent with policy previously adopted by the FMA House of Delegates. The amendment was defeated and the House adopted the following amendment to the Reference Committee report:

RESOLVED, That it be the policy of the American Medical Association that the hospital admitting privilege be granted in accordance with state law and in accordance with the criteria for standards of medical care established by the individual hospital medical staff; and be it further

RESOLVED, That this policy be transmitted to the Joint Commission on Accreditation of Hospitals.

House of Delegates' Actions

The House considered a wide range of subjects covering many aspects of medicine. A detailed report regarding the actions of the House will be included in other FMA publications and newsletters.

COMMITTEE ON ALLIED HEALTH GROUPS

Advanced Registered Nurse Practitioners

Requested that the Committee continue to monitor closely the development of rules by the Joint Committee of the State Board of Medical Examiners and Board of Nursing regarding additional acts to be performed by ARNPs and the number of ARNPs which may be supervised by one physician or dentist.

COUNCIL ON LEGISLATION

Professional Liability

Approved the recommendation that the FMA maintain legislative posture relative to tort reform and that any proposed legislation embody the same principles as those recommended for submission to the public for constitutional revision including summary judgments, elimination or limitations on noneconomic damages, and elimination of joint and several liability.

Positive Legislative Initiatives

Approved FMA seeking legislative support for the following programs as important components in an overall effort to improve the health of Florida citizens:

- Hazardous waste monitoring;
- Increasing the drinking age to 21;
- Increased support for medical services for indigent patients.

Constitutional Initiative for Drinking Age

Approved the appointment of an FMA representative to the Board of Directors of the organization seeking a constitutional amendment to raise the drinking age in Florida to age 21.

Foreign Medical Graduates

Approved the concept of the need for improved quality control over licensure of foreign medical graduates and their ability to stand for licensure examination in Florida; and further, that the proposal by the Florida State Board of Medical Examiners for inspection of foreign medical schools be referred to the FMA Committee on Medical Education for evaluation and recommendation.

Quintas

Authorized the FMA to continue to monitor the problems relating to "quintas" in South Florida and their apparent failure to meet standards required of prepaid health plans by Florida law; and that the FMA suggest that resolution of this issue is more properly one of enforcement of current law and regulation rather than legislative initiative; and further, that the FMA offer its assistance to the State Insurance Commissioner and the Department of Health and Rehabilitative Services as may be helpful in developing an appropriate resolution.

American Association of Retired Persons

Encouraged all FMA members who are eligible to join the American Association of Retired Persons (AARP).

Health Care for the Indigent

Requested that the Council on Medical Economics develop specific recommendations for the development of a total health care system for indigent patients and submit its recommendations to the Board of Governors at its next meeting.

Legislative Priorities

Adopted the FMA's position regarding the following legislative proposals to be Session, and others which may be proposed.

Opposition to Legislation:

- Legislation authorizing use of drugs for treatment of disease by optometrists;
- Creating a new classification of pharmacist known as "Pharmacist Health-Care Consultant" as proposed in Senate Bill 45 and House Bill 104;
- Nurse anesthetist hospital staff privileges;
- Removal of the exemption for records and proceedings of medical staff committees from the Open Records Law;
- Continuation of Chapter 467, F.S., relative to the licensure of lay midwives;
- Legislation requiring hospitals to allow chiropractors access to outpatient diagnostic facilities;
- Legislation permitting hospitals and ambulatory surgical centers to maintain and update records on elective surgery;
- Legislation removing the exemption from the Open Records Law of complaints against regulated professionals, regardless of whether or not probable cause is found;
- Legislation creating a licensure statute for respiratory therapists;
- Proposed changes in the current radiologic technologist law that would increase the educational requirements and make the examination standards more stringent for physician office personnel;
- Legislation mandating state regulation of hospital rates or budgets.

COUNCIL ON SPECIALTY MEDICINE

Respiratory Therapists

Endorsed credentialing through the certification process for respiratory therapists and expressed opposition to any type of licensure.

Radiologic Technologists

Endorsed legislation to encourage a more stringent examination for advanced level radiologic technologists with continuation of the two categories for certification.

Specialty Group Recognition

Approved continuing recognition for the following specialty groups who have met the criteria established by the FMA House of Delegates:

Florida Allergy and Immunology Society
Florida Chapter, American College of Chest Physicians
Florida Society of Colon and Rectal Sugeons
Florida Chapter, American College of Emergency Physicians
Florida Academy of Family Physicians
Florida Society of Internal Medicine
Florida Society of Nephrology
Florida Neurosurgical Society
Florida Obstetric and Gynecologic Society
Florida Society of Ophthalmology
Florida Society of Otolaryngology/ Head and Neck Surgery
Florida Association of Pediatric Cardiologists
Florida Association of Pediatric Surgeons
Florida Society for Preventive Medicine
Florida Radiological Society, Inc.
Florida Chapter of American College of Surgeons
Florida Thoracic Society

Anabolic Hormone Bill

Approved in principle FMA support for legislation to oppose the Anabolic Hormone Bill.

Medical Doctor Inventory Form

Endorsed the principle of physician compliance with the 1983-84 Medical Doctor Inventory Form.

COUNCIL ON MEDICAL ECONOMICS

PRO Board of Directors

Approved appointment of the following physicians as subscribing members to the FMF/PRO Board of Directors in accordance with the actions taken by the Board at its meeting in October 1983 that composition of the Board include five members appointed by the FMA and two members by the Florida Osteopathic Association and that the additional appointments to the Board of Directors of four physician members (one elected from each FMA medical district or PRO districts that may be created) be considered by the subscribing members of the PRO Board at the appropriate time subject to approval by the FMA Board of Governors:

Florida Medical Association, Inc.

A. Frederick Schild, M.D., Miami
James D. Morgan, M.D., Winter Haven
Charles E. Cernuda, M.D., Tampa
Charles P. Hayes Jr., M.D., Jacksonville
James M. Potter, M.D., Pensacola

Florida Osteopathic Medical Association

John Hackenberg, D.O., Jacksonville
Perry M. Dworkin, D.O., Miami

COUNCIL ON MEDICAL SERVICES

Prescription Abuse Data Synthesis

Adopted a proposed policy statement on Prescription Abuse Data Synthesis (PADS) to be submitted to the State PADS Project.

Pediatric Emergency/ Critical Care/Trauma Network

Reaffirmed the concept endorsed by the Florida Medical Foundation EMS project for establishing a pediatric emergency/critical care/trauma network within the Children's Medical Services (CMS) programs of DHRS.

The Board supported enactment of legislation establishing and identifying appropriate criteria for a CMS emergency medical/critical care/trauma/poison control program which will effectively interface with the ongoing, statewide, CMS Perinatal Intensive Care Program and will also ensure optimum utilization of other related CMS services, including the Neonatal Intensive Care Communication (Care-Line) Transport System and the CME Pilot Program for Poison Control.

Public Relations Program

Approved development of an FMA educational public relations program that will illustrate the significant role of emergency medical services in Florida's health care system.

JUDICIAL COUNCIL

Amendment to Medical Practice Act

Expressed support for an amendment to Florida's Medical Practice Act to remove the current restriction relating to membership on the State Board of Medical Examiners that prevents faculty members of medical schools from serving on the Board.

COMMITTEE ON IMPAIRED PHYSICIANS

Voluntary Contributions

Approved an ongoing solicitation for voluntary contributions to the FMA Impaired Physicians Program Loan Fund to be conducted through *The Journal of the Florida Medical Association, Inc.*, and other FMA publications.

PRESIDENT'S PAGE

FMA House of Delegates resolute and unified on professional liability issue



It is with a deep sense of pride that I relate to you the actions of your Florida Medical Association House of Delegates at its special Called Meeting on Saturday, January 28, 1984. The House of Delegates met in Executive Session to consider the report and recommendations of the Board of Governors regarding the Association's future activities in resolving the continuing and worsening professional liability crisis in Florida. The report and recommendations of the Board, as amended and overwhelmingly adopted by the House of Delegates, are outlined in the "Proceedings of the House of Delegates Called Meeting" included in the February issue of *The Journal of the Florida Medical Association, Inc.*

You would have been proud to have observed the sincere interest and conscious concern every Delegate demonstrated in deliberating this enormously complex and difficult issue. Two hundred nine Delegates, representing 39 of the FMA's 46 component county medical societies, attended the meeting. It was clear throughout the deliberations that the future best interest of all physicians and their patients remained uppermost in the minds of the Delegates. I am also proud of the total unity and democratic manner in which the House of Delegates deliberated the Association's future course. The House acted as its own Reference Committee, during which time the FMA members present had an opportunity to express their views regarding every aspect of the professional liability problem and the Board's recommendations. When the time came to decide on which course to follow, the House of Delegates acted resolutely, with harmonious unity, and without a single dissenting vote.

Now I am asking that each of you lend your full support as together we embark on perhaps the most important task that our Association has ever undertaken. In the near future, each FMA active dues-paying member will be receiving a notice requesting payment of the $300 assessment approved by the House of Delegates to implement our professional liability program. I am totally confident that each of you will respond promptly and enthusiastically. More importantly, I hope that you will make a personal commitment to actively participate in this important undertaking when called upon. At a special called meeting of the Board of Governors on February 11, 1984, the Board approved a meeting of the entire Florida Medical Association and FMA Auxiliary membership, to be held on Thursday, March 8th, from 8:00-9:15 p.m. EST (7:00-8:15 p.m. CST) via teleconferencing, to more fully inform you regarding implementation of the professional liability program approved by the House of Delegates. A letter is being sent to all FMA and Auxiliary members outlining details of the meeting including locations throughout the state where the program may be viewed.

It has been said that our greatest successes result from our most difficult tasks. I firmly believe that together we will succeed in this noble cause — a cause that will help preserve our profession; a cause dedicated to the future health and welfare of the patients we serve.

J. Lee Tackett



Working together.
It can make the difference.

There are certain times when working together helps you accomplish what you couldn't alone.

In the medical profession, it can save lives.

The American Medical Association and your state and county medical societies believe in the value of teamwork — and the necessity of it, in the face of an increasingly complex professional environment.

We also believe that medical societies have certain tasks that the individual physician couldn't possibly assume — and shouldn't have to.

For example, to keep government regulations from interfering with your practice, we effectively represent your interests at local and national levels.

And to keep you up to date on the latest medical advances, we publish JAMA, specialty, state, and county journals.

Why do we believe that teamwork can make such a difference?

Because the very existence of the AMA is solid proof that when physicians work together, they can make their own decisions, protect their own freedoms, and control their own destinies.

And when you have a goal like that, working together makes all the difference in the world.

Join Your Medical Societies Today.

For more information, contact your county or state medical societies, or call the AMA collect at 312/751-6196. Or return the coupon below to your state or county medical society.

☐ Please send me information on AMA, county, and state society membership.

☐ I am a member of my county and state societies; please send me information on joining the AMA.

Name _____

Street _____

City _____ State _____ Zip _____

County _____

Deprecation of image

The American physician has found himself in recent years in a chillier climate of national opinion. The public is questioning whether money and prestige outweigh humanitarianism as the professional raison d'etre. Many now think of doctors as men and women concerned first with personal gain and only secondly with the welfare of the sick. Many physicians are generally perceived as nothing more than money making machines.

In certain circles physicians are regarded as venal, smug, aloof from human suffering and contesting every social advance that might offer better care to the medically indigent groups.

What are the reasons for the currency of the grotesque public image? Why is public hostility toward the medical profession mounting rather than diminishing? The chief complaint of the patients in public-opinion polls and medical-sponsored surveys was that the physicians lacked "human warmth."

One important reason is probably the change in the nature of medical practice from an intensely personal service to the objective and highly scientific approach demanded by the sophistication of modern biological theory. Medicine has become complex and esoteric and more difficult to expound to the medically uneducated.

The physician's attempts to preserve his individual freedom and responsibility in his previously private practice are seriously minimized by an increasing public practice of medicine. Oligarchies of commercial, public health and research organizations are slowly taking over the providence of actual treatment.

It may be that physicians evoke unjustified hostilities but still we must admit that there is some truth in the changing view of the doctor held by a mounting proportion of the public. Instead of becoming a professional elite, drawn from and cutting across from every social stratum, at the service alike of beggar and banker, physicians have drifted into an upper class status identification that prevents the physician from recognizing the wishes and needs of the great mass of the American people.

Many physicians have avoided responsibility for their lowered prestige, lashing out at scapegoats: the press, the labor unions, the federal government, etc. A few maturely place the fault directly at their own feet.

F. Scott Fitzgerald wrote, "No Achilles heel ever toughened by itself. It just gets more and more vulnerable." The continuing loss of prestige is a physician's Achilles heel. Physicians should realize that their fading image will make free organized medicine more vulnerable to socialism.

If we hope to repair the image of the physician we must replace the managerial paternalism of a simple age of medicine and draw upon the arts of psychological healing. We must move away somewhat from our devotion of the psychology of persuasion to the more farsighted viewpoints associated with the psychology of responsibility.

It is up to every individual physician not to order diagnostic admissions to hospitals in the guise of therapy, not to countenance extended hospital stays, not to indulge in patients' demands for miracle drugs and batteries of lab tests and not to perform unnecessary surgery.

Physicians should not participate in the national medication orgy for self-limiting illnesses. Physicians should not yield to the compulsion to drug every symptom of the complaining patient. Physicians should put an end to the mammoth program of physician-courting by the drug industry.

The physicians' prestige woes should be the concern of every individual. We must all work to resolve this Achilles heel. We must crystallize and effectuate a potent opposition to the deprecation of the physician's image.

Attempting no solution to the continuing loss of prestige will be a forfeit for socialized medicine. Increasing deprecating physician images and socialized medicine are inseparable!

Physicians, the loss of prestige is a poison. An immediate antidote: every physician must strive to be perceptive, concerned, honest, articulate and especially compassionate.

Physicians should remember the words of the Sixteenth Century Physician, Paracelsus: "A physician should exercise his art — not for his own sake — but for the sake of the patient; if he practices merely for his own benefit such a physician resembles a wolf."

Edward Pedrero Jr., M.D.
Tampa

Warren Wilson Quillian, M.D. (1901-1984)

As I remember him he was a friendly, competent, quiet man who could always be depended upon for wise counsel. He willingly accepted his responsibilities to his family, patients, community and professional colleagues.

The biographical details are: born in Atlanta, June 22, 1901; graduated at Emory University School of Medicine, 1924; came to Dade County in April 1926; established a large practice limited to pediatrics in Coral Gables; served as a United States Navy Medical officer attached to the Marine Corps, 1941 to 1945; returned to his practice at the War's end; retired in 1978 and died of carcinoma of the pancreas at his home, January 10, 1984.

However this perfunctory recitation does not give the measure of the man. It tells nothing of the hours he gave to community service as in his efforts to improve the Dade County milk supply or the hours devoted to his church, The Coral Gables First Methodist Church. It overlooks his contributions in the launching of the Variety Children's Hospital, now known as the Miami Children's Hospital, and the Doctors' Hospital. It fails to reveal his integral part in establishing the Pediatric Section of the University of Miami School of Medicine and his service as President of the Miami Pediatric Society, the Florida Pediatric Society and the American Academy of Pediatrics. And it makes no mention of his contributions to the Dade County Medical Association (President, 1947), the Florida Medical Association (President, 1963) and his presidency of Blue Shield of Florida.

Most importantly it ignores the human side of the man. He was a caring human being. For example during the bleak years of the Great Depression, when the situation warranted, he not only gave freely of his services, but at times from his own pocket furnished the food and medicines that sustained the patient and family.

In a word he was a physician in the finest sense and our community is better off for his having lived. We who knew him will forever miss him.

William M. Straight, M.D.
Miami



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Imported fire ant death

A documented case report

Frederick L. Bloom, M.D., and Patrick R. DelMastro, M.D.

ABSTRACT: A well documented anaphylactic death from Solenopsis invicta Buren, the imported fire ant, is reported. As the population of Florida grows, increasing numbers of people are at risk for serious reactions. At this time there are no methods available for controlling this insect.

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There have been many reports in the scientific literature on imported fire ant hypersensitivity.[1-5] Some reactions have been extremely severe and there has been, at least, one reported case of successful resuscitation of the same individual on three separate occasions.[6] Several species of fire ants have been reported to cause systemic allergic reactions, however, *Solenopsis invicta* Buren is most often incriminated as a cause of hypersensitivity reactions in the southeastern United States. In spite of anecdotal reports of fatal reactions, no cases have been well documented. We report such a case which occurred in Sarasota, an area on the southwest coast of Florida with a very heavy concentration of *S. invicta*.

Case report ● The patient, a 60-year-old white female native of Wisconsin, had moved to Sarasota approximately one year before this hospital admission. She had visited the west coast of Florida during the winter for the preceding three years but had never informed family members of unusual reactions to insect stings and bites which occurred. She had hypertension which was controlled by Inderide (propranolol and hydrochlorothiazide) but other past medical history was unremarkable. Family history was also unremarkable for atopic disease or insect hypersensitivity.

On the day of admission, the patient was hanging clothes in her yard when she noticed she was being stung by fire ants. She made her way unassisted into the house and sat down. Immediately her adult daughter washed and began to soak the stung legs in a bucket of water. At that time she stated that she felt somewhat dizzy and tired. After about five minutes, she began to complain of some mild shortness of breath and her daughter asked if she should call her local physician. She gave a negative reply, but subsequently agreed to having her physician telephoned and her daughter left the room to place the call. While on the phone, the daughter heard her mother calling. She ran back into the room and found that she had fallen from the chair and was lying on the floor in obvious distress.

The daughter described her mother as red in the face and with an over all elevated body temperature. She was conscious but her speech was garbled and she was grasping at her throat. There was audible wheezing and shortly thereafter cyanosis followed by extreme shortness of breath and, finally, the patient become nonresponsive. After approximately three minutes, the daughter contacted the emergency medical service and the ambulance arrived at the scene ten to 15 minutes later. During this time the patient continued to have markedly labored respiration. Upon arrival the emergency medical technicians found her to be comatose, with stertorous respiration, audible wheezing, and with no palpable blood pressure. The patient was placed in a mast shock suit, intravenous medications were given, and she was transported to the emergency room. Upon arrival she had spontaneous respirations but was hypotensive and nonresponsive. Clinical examination showed conjunctival edema, marked edema of the eyelids, peripheral cyanosis of the hands and large areas of urticaria on the neck, midabdomen, and lower extremities. Pupils were at mid-point and reacted sluggishly to light. Corneal reflexes were absent. Chest examination revealed wheezes scattered throughout the lung fields. Cardiac examination revealed normal S1 and S2 with no murmur, gallop, or rub. Pulse was 110/minute.

Laboratory data • The white blood cell count was 16,300 with hemaglobin 18.9 and hematocrit 53%. This high WBC with a shift to the left and elevated hematocrit would be compatible with manifestation of anaphylactic shock. EKG initially showed no evidence of acute myocardial infarction and appeared to be within normal limits. Chest x-ray showed cardiomegaly with no upper lobe hypervascularity. Arterial blood gases showed hypercarbia of 52 with $Pa0_2$ 70 and pH 7.25 with ambu bag and spontaneous respirations.

Treatment • The resuscitative procedures used in the emergency room were endotracheal intubation and insertion of a Swan-Ganz catheter. At that time the patient's respiration required mechanically assisted ventilation. Medications used during initial resuscitation were epinephrine, Vistaril (both standard procedure in anaphylactic shock treatment), Benadryl, Solu-Medrol, aminophylline, Levophed, dopamine, and IV fluids of normal saline, 0.9%, and plasmanate-colloid replacement. An electroencephalogram showed diffuse, slow activity in both beta and delta frequencies. This reading is consistent with severe generalized cerebral disturbance. Later, repeated tracings showed further deterioration of brain functions. Once stabilized the patient was moved to the intensive care unit.

Hospital course • In ICU she was maintained on full life-support systems with full hemodynamic monitoring. Further testing revealed that she had suffered an acute myocardial infarction (subendocardial) sometime after the initial EKG was taken in the emergency room. During the course of management and support in ICU, she demonstrated no progress in neurological status. She was treated for several urinary tract infections and gram negative sepsis and was fed by nasogastric tube. Subsequently she regained respiratory function and was weaned from the respirator. This allowed her to be transferred to a medical floor.

After determination that the maximum hospital benefit had been achieved, the patient was admitted to a nursing home. At the time of hospital discharge hemoglobin was 12.7, SMA 6 was wnl and U/A was also wnl. She died in the nursing home approximately five months after encounter with *S. invicta.*

Ants from the area of the yard where the patient had been stung were collected and sent to the University of Florida Institute of Food and Agricultural Sciences. An entomologist identified them as *Solenopsis invicta* Buren.

The patient had been seen 24 and 48 hours after hospital admission by an allergist familiar with fire ant stings and reactions. He found eight intact, classic small pustules on a very small erythematous base which is indicative of the fire ant sting.

Discussion • The imported fire ants, *Solenopsis invicta* Buren and *Solenopsis richteri* Forel, were brought into this country accidentally through the port of Mobile, Alabama from Brazil, Uraguay and Argentina. The native species, *Solenopsis geminata* and *Solenopsis xylone,* are also found in the southeastern United States. They are, primarily, forest dwelling ants. *S. invicta* normally inhabits open grasslands. With environmental changes such as stripping of forest for timber, farm lands, and building of cities and roads, an ecologic vacuum has been formed which has been fully exploited by *S. invicta.* This species is predisposed to areas where earth is being moved or where new construction is under way. Because of its aggressive nature, *S. invicta,* is "now the dominant formicid in a very large area of the southern United States."[7] Inhabiting billions of nests, *S. invicta* is distributed over 200 million acres with a total ant mass estimated to be in the range of ½ to 1 million tons.[8] The imported fire ant's habitat extends from the Atlantic Ocean on the east, south through Florida, and as far west as mid-Texas. Their westward migration will only be stopped by the Pacific Ocean. Because they do not thrive in colder climates, the fire ant is usually found only as far north as southern North Carolina and southern Tennessee. It is an extremely aggressive organism and will swarm to attack any intruder who may wander onto its mound.

The incidence of systemic reactions to fire ant stings in the general population of an infested area is

four persons per 100,000 per year.[5] The trend is toward an increasing incidence of systemic reactions and a higher number of nonallergic complications such as secondary infections which require debriding and skin grafts.[4] The low incidence figure of four persons per 100,000 of a given population reactive to fire ants probably does not scratch the surface of patients actually affected by this insect's sting. Patients who have acute anaphylactic reactions to unknown agents, patients who suffer unexplained deaths for which a cause is never determined, and those found to have probable myocardial infarction could conceivably be the victims of the fire ant's sting. In many of these cases the pustules are either ignored or thought not to be of significance. Although the number cannot be substantiated, estimates as high as eight persons per 1,000 with systemic allergic reactions to *Hymenoptera* stings (the fire ant is one of the *Hymenoptera)* have been published, which is 200 times above our minimal incidence figure.[9,10] Surveys by a group at the University of Florida have indicated that the incidence of systemic allergic reactions to the imported fire ant sting in Florida exceeds the combined incidence of systemic reactions to all other stinging *Hymenoptera.*[5]

The method of stinging is unique in that the insect secures itself with its mandibles and then using its head as a pivot swings its abdomen in an arc stinging repeatedly with its abdominal stinger. This stinger is a modified ovipositor, nonserrated and nonbarbed. The sting is felt as a burning pain. The venom is unique and isomers of it are found no where else in the animal world. Greater than 95% of the fire ant venom is composed of simple disubstituted piperidine alkaloids which are thought to be nonallergenic.[11] The venom is necrotoxic, hemolytic, insecticidal but not for the fire ant, bactericidal and causes activation of the alternate complement pathway.[12] The aforementioned properties account for the unique sterile pustule on an erythematous base which occurs 16 to 24 hours after a *S. invicta* sting in about 84% of the reported sting cases. Only members of the *Solenopsis* group produce this pustule. There have been reported incidents of alcoholics and children who suffered no systemic reactions after having been stung repeatedly by *S. invicta.* Several studies have been done to try and define the allergens in the venom. Because the venom is extremely difficult to obtain in quantity, the possible clinical usefulness of whole body extract has been studied. The relationship between whole body extract and pure venom has also been investigated.[11,13-15] Three different proteins, which have allergenic activity, have been identified by Dr. Harold Baer of the N.I.H.[11] Venom has been shown to contain the enzyme activities of phospholipase and hyaluronidase.[11]

Invicta means unconquered and that is the status of the fire ant at this time. Mirex (dodecachloroocta-hydro-1,3,4,metheno-2H-cyclobuta(c d) pentalene), the insecticide most specific and effective in control of fire ants, has been taken off the market by the Environmental Protection Agency because of potential carcinogenesis. It has been found to accumulate in human fatty tissue. Other insecticides have been used with less than satisfactory results and at this time there is no effective control for this insect. Presently, Amdro (tetrahydro-5, 5-dimethyl-2[1H]-pyrimidinone[3-[4[trifluromethyl]phenyl]-1-]2-[4-trifluromethyl]phenyl]ethenyl]-2-propenylidene]hydrazane) would appear to be the best of the legally available insecticides.[16] With increasing density of the fire ant population, we can project a further increase in the number of reported cases of stings. Many individuals may have their lives threatened or lifestyles greatly altered by this problem. With the continued population shift to be southern regions of the United States, we are bound to observe an increase in the significance of the imported fire ant as a medical problem.

The venom of the fire ant appears to be extremely simple. If the small polypeptides or proteins are the antigen, the simplicity of the aqueous phase makes it highly amenable to purification and analysis. The only real problem would be the extremely small volume of venom available from a single ant. The need for a purified venom fraction increases each year. Hopefully a more refined agent will be available in the near future for testing and the possible treatment of fire ant sting victims.

Acknowledgments

We acknowledge our indebtedness to Alan Grindal, M.D., Crawford Hawkins, M.D., Robert Rhoades, M.D., and Mary B. Thomas for assistance in the care of this patient and/or in preparation of this paper.

References

1. Helmly, R.B.: Anaphylactic Reaction to Fire Ant, Hawaii M. J. 29(5); 368-69, 1970.
2. Triplett, R.S.: Sensitivity to Imported Fire Ant: Successful Treatment with Immunotherapy, South. M. J. 66(4):477-480, 1973.
3. Lockey, R.S.: Systemic Reactions to Stinging Ants, J. Allergy and Clin. Immunol. 54(3):132-146, 1974.
4. Rhoades, R.B.; Schafer, W.L.; Schmid, W.H.; Wubbena, P.F.; Dozier, R.M.; Townes, A.W., and Wittig, H.J.: Hypersensitivity to Imported Fire Ant, J. Allergy Clin. Immunol. 56(2):84-93, 1975.
5. Rhoades, R.B.; Schafer, W.L.; Newman, M.; Lockey, R.; Dozier, R.M.; Wubbena, P.F.; Townes, A.W.; Schmid, W.H.; Neder, G.; Brill, T., and Wittig, H.J.: Hypersensitivity to Imported Fire Ant in Florida, Report of 104 Cases, J. Florida M. A. 64:247-254, 1977.
6. Bloom, F.L.; Spangler, D.L.; Wittig, H.J., and Rhoades, R.B.; Imported Fire Ant Rapid Hyposensitization, J. Allergy Clin. Immunol. 61(3):134, 1978.
7. Buren, W.F.; Allen, G.E.; Whitcomb, W.H.; Lennartz, F.E., and Williams, R.N.: Zooeography of Imported Fire Ant, J. New York Entomological Society, 82(2): 113-124, 1974.

8. Buren, W.F.: Personal Communication, Gainesville, FL. April 12, 1976.
9. Lichtenstein, L.M.; Valentine, M.D., and Sobotka, A.K.: Case for Venom Treatment in Anaphylactic Sensitivity to Hymenoptera Sting, N.E.J.M. 290(22):1223-1227, 1974.
10. Schuberth, K.D.; Lichtenstein, L.M.; Kagey-Sobotka, A.; Szklo, M.; Kwiterrovich, K.A., and Valentine, M.D.: Epidemiologic Study of Insect Allergy in Children. I. Characteristics of Disease, J. Pediat. 100(4):546-551, 1982.
11. Baer, H.; Liu, T.-Y.; ANderson, M.C.; Blum, M.; Schmid, W.H., and James, F.K.: Protein Components of Fire Ant Venom *(Solenopsis invicta)*, Toxicon 17:397-405, 1979.
12. Rhoades, R.B.; Medical Aspects of Imported Fire Ant, University Presses of Florida, Gainesville, Florida, 1977.
13. James, F.K. Jr.; Pence, H.L.; Driggers, D.P.; Jacob, R.L., and Horton, D.E.: Imported Fire Ant Hypersensitivity, J. Allergy Clin. Immunol. 58(1):110-120, 1976.
14. Rhoades, R.B.; Kalof, D.; Bloom, F.L., and Wittig, H.J.: Cross-Reacting Antigens Between Imported Fire Ants and Other Hymenoptera Species, Ann. Allergy 40:100-104, 1978.
15. Rhoades, R.B.; Newman, M.; Bloom, F.L., and Wittig, H.J.: Skin Testing with Venom Fractions of Imported Fire Ant, J. Allergy Clin. Immunol. 61(3): 134, 1978.
16. Institute of Food and Agricultrual Sciences, University of Florida, Personal Communication, May 1982.

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Nephrolithiasis during pregnancy
Role of uterus and fetal head manipulation in management

Pawan K. Rattan, M.D.; Robert A. Knuppel, M.D.; and Jose C. Scerbo, M.D.

ABSTRACT: A case is presented of ureterolithiasis completely blocking the right ureter complicating pregnancy at 33 weeks gestation. Management by the transurethral cystoscopic ureteral stent catheter technique is described. The role of the uterus and fetal head as a cause of difficulty in passage of the catheter is discussed.

Ureteral calculi are uncommon during pregnancy, but the sequelae of compromised renal function and urinary tract infection for both mother and fetus are real, depending on location of the calculus. Transurethral cystoscopic basket extraction of the stone is considered the first choice in operative management. The role of fetal head manipulation during this procedure has not been previously described. Herein we report a case which suggests this may occasionally make a critical difference in the success of the procedure.

Case report • A 20-year-old female, gravida 3, para 1, with an estimated date of confinement of 5/7/82 was seen at 33 weeks of pregnancy complaining of severe right flank pain which radiated to her right groin. Urinalysis revealed 10-15 white blood cells per high field and 300 red blood cells. A diagnosis of renal stone was proved by one-shot intravenous pyelogram (IVP). The left kidney and ureter were normal and there was right hydronephrosis and hydroureter. A one-hour postinjection film demonstrated an enhanced nephrogram without dye present in the right distal ureter. This confirmed complete ureteral obstruction on the right side. (Figs. 1, 2).

Under local anesthesia the patient underwent a transurethral cystoscopic examination and a trial to insert a ureter stent catheter which was unsuccessful. Conservative management was maintained for one week but the calculi failed to pass spontaneously. The decision was made to utilize transurethral cystoscopic ureteral stent catheter placement. The urologist was assisted by an obstetrician who vaginally displaced the fetal head out of the maternal pelvis and held it in place abdominally. This manipulation may have made the critical difference in the ureteral stent catheter passing by the ureteral stone. This procedure was successful.

The patient was readmitted at term with a mature L/S ratio and labor was successfully induced with delivery of a healthy female baby which weighed 2920 grams and had apgars of 9 and 9. There were no complications.

The Authors
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Fig. 1. — Intravenous pyelogram at five minutes showing calculus (C), right hydronephrosis, and hydroureter. Fetus vertex presentation.

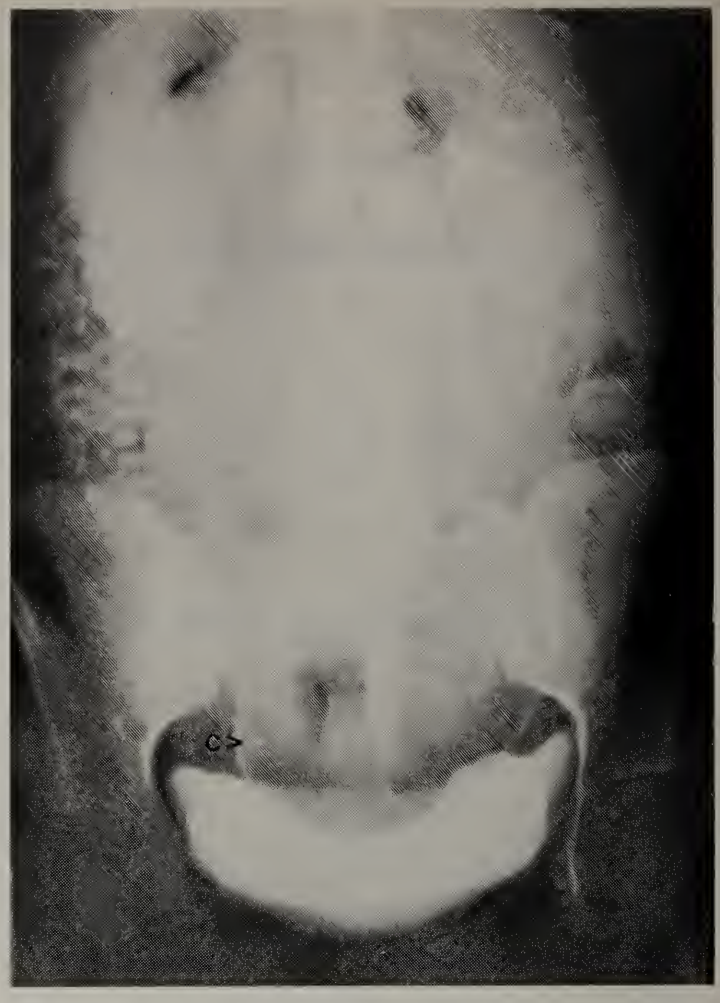


Fig. 2. — Intravenous pyelogram at one hour delayed showing calculus (C).

The patient had an unremarkable postpartum course and was evaluated by the urologist with an IVP that showed persistent dilatation of the right ureterocalyceal system. The stones essentially were unchanged in position (Fig. 3). She was readmitted two weeks postpartum complaining of fever and chills. A cystourethroscopy and right ureteral catheterization with an attempt at endoscopic basket extraction of the stone failed. The patient underwent an open right ureteral lithotomy and two stones were removed. Postoperatively the patient had a temperature elevation to 38.3C and 38.9C. The urine culture grew 4,000 colonies of beta streptococci. She was placed on Mandol and gentamicin. She was afebrile for a period of five days and was discharged home on the sixth postoperative day to be followed in the clinic.

Comment • The incidence of renal stones has been found in pregnancy to average 1 per 1,704 deliveries or 0.059%.[1] The incidence of complete ureteral obstruction is even less common.

Management of urinary calculi during pregnancy must be individualized and should be based upon location of stone, degree of obstruction, presence or absence of infection, condition of the patient and stage of pregnancy. Surgical intervention for removal of the obstructing calculi is not contraindicated in pregnancy.[2]

Jones et al[1] have recommended that in the presence of an infection use of an antibiotic and cystoscopic manipulation or placement of a ureteral catheter proximal to the obstruction should be attempted before an open procedure.

Dilatation of the renal tract is acknowledged to be almost universal in pregnancy and is probably more common on the right side due to the more common dextrorotation of the uterus. It is generally accepted that the cause of this dilatation is not solely endocrinologic but also due to ureteric obstruction by the gravid uterus at the pelvic brim.[3] The pelvic ureter is not dilated. Such obstruction of the ureter is usually asymptomatic although acute renal failure secondary to uteral obstruction[4] by a gravid uterus and a ruptured ureter[5] have been described. Thus, any manipultion in the ureter is definitely hindered by the external pressure of the gravid uterus along with the fetal head.

Endoscopic basket extraction is the preferred choice for removal of ureteral stones which are symptomatic during pregnancy.[6] From our review of the literature, fetal head and gravid uterus manipulation during transurethral cystoscopic manipulation of the ureteral stone has not been described.



Fig. 3. — Postpartum film showing calculi in renal pelvic (A), ureteral stent catheter (B), and ureteral calculus (C).

Summary • This case illustrates successful interim management of complete ureteral obstruction by placement of a ureteral stent earlier seen to be impossible until elevation of the fetal head was accomplished. This maniuplation along with the gravid uterus may have made the procedure easy and successful. We suggest that this be considered in all cases when there is difficulty in passing the ureteral catheter.

References

1. Jones, W.A.; Correa, R.J.; and Ansell, J.S.: Urolithiasis Associated with Pregnancy, J. Urol. 122:333-335, 1979.
2. Strong, D.W; Murchison, R.J.; and Lynch, D.F.: Management of Ureteral Calculi During Pregnancy, Surg. Gynecol. Obstet. 146:604-608, 1978.
3. Weiss, R.M.: Clinical Implications of Ureteral Physiology, J. Urol. 121:401-413, 1979.
4. Hamilton, D.V.; Kelly, M.B.; and Pryor, J.S.: Polyhydramnios and Acute Renal Failure, Postgrad. Med. 56:798-799, 1980.
5. Eaton, A. and Martin, P.C.: Ruptured Ureter in Pregnancy — Unique Case? Br. J. Urol. 53:78-79, 1981.
6. Meares, R.M.: Urologic Surgery During Pregnancy, Clin. Obstet. Gynecol. 21: 907-920, 1978.

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Antenatal sonographic detection of posterior urethral valves

Bruce A. Rodan, M.D.; William J. Bean, M.D.; and Diane Rohde, R.T., R.D.M.S.

ABSTRACT: Prior to obstetrical sonography, diagnosis of developmental anomalies of the fetal genitourinary system was usually delayed until the neonatal period. Ultrasound examination now readily provides information about the developing fetus. Our findings of bilateral hydroureteronephrosis and persistent bladder distension in a male fetus allowed us to make a presumptive diagnosis of posterior urethral valves. Since this was anticipated at birth, prompt evaluation and treatment minimized the risk of further damage from prolonged obstruction and infection.

Posterior urethral valves are the most common cause of urethral obstruction in the male infant. The severe cases present early with bilateral flank masses and a distended bladder on physical examination. A weak urinary stream may be noted; however, clinical presentation may be delayed until infection develops or the infant fails to thrive. Classically the diagnosis has been established by voiding cystourethrography.

We present a case in which posterior urethral valves were suggested antenatally by ultrasound examination; thus allowing prompt neonatal evaluation and treatment.

Case report • The patient, a 30-year-old hospital employee, primagravida, 36 weeks gestation by dates, desired to "see" her baby during this uneventful pregnancy. The coronal B-scan performed with a Picker 80-L (Fig. 1) of the fetal abdomen demonstrated multiple sonolucent structures representing the distended bladder and renal collecting systems in addition to the more cephalad cardiac chambers. Bilateral hydroureteronephrosis was present. The bladder failed to adquately empty during the period of observation. A normal amount of amniotic fluid was present. Figure 2 is a real-time image using the ATL Mark III sector scanner revealing testicles and an incidental right hydrocele identifying the fetus as a male. This constellation of findings suggested the diagnosis of posterior urethral valves and after routine delivery these were verified and corrected.

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Discussion • Prior to use of obstetrical sonography, diagnosis of developmental fetal genitourinary anomalies was delayed until after delivery; now this procedure allows visualization of the urinary tract by the 15th menstrual week and also detection of anomalous development in utero.[1-4] Most renal

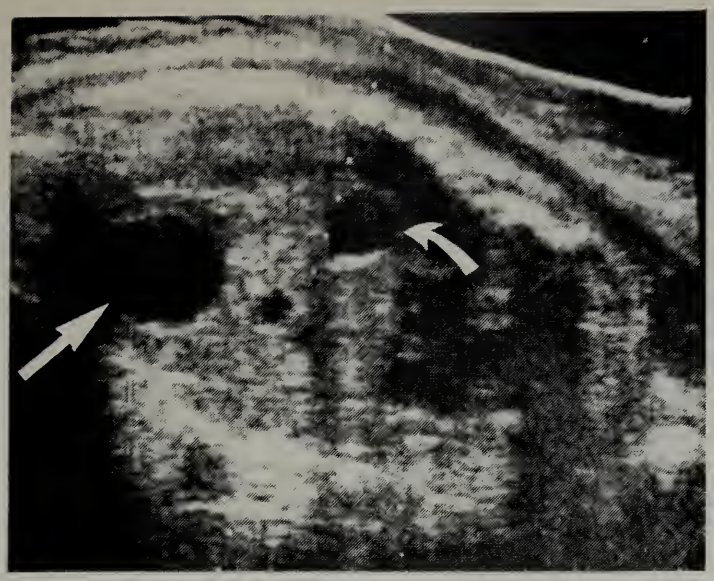


Fig. 1. — Coronal B-scan of the fetal abdomen demonstrates the distended bladder (straight arrow) and renal collecting system (curved arrow).



Fig. 2. — Real-time image revealing testicles and an incidental right hydrocele (arrow) identifying the fetus as a male.

anomalies are incidental findings on sonographic examination and depend upon the level and degree of the obstruction.

Posterior urethral valves are the second most frequent cause of neonatal hydronephrosis.[5] Urethral obstruction usually produces a grossly enlarged bladder with hydroureter and hydronephrosis and is frequently associated with oligohydramnios. This appearance, however, is nonspecific for posterior urethral valves and may be seen with other obstructing lesions of the lower urinary tract as well as nonobstructing conditions, e.g. ureterovesical reflux and "prune belly" syndrome.[4] Bladder wall thickening and dilatation of the prostatic urethra should be sought as a more specific sonographic sign of urethral obstruction.[6] Sonography alone often cannot differentiate obstructive from nonobstructive collecting system dilatation. Cystography and excretory urography adds important data to the evaluation of patients with these conditions.[7]

Male infants with posterior urethral valves often demonstrate renal failure, dehydration, and sepsis at age two to four weeks. Since this diagnosis was anticipated at birth in our patient, prompt evaluation and treatment minimized the risk of further damage from prolonged obstruction and infection.

References

1. Hadlock, F.P.; Deter, R.L.; Carpenter, R., et al: Sonography of Fetal Urinary Tract Anomalies, Am. J. Roentgenol. 137:261-267, 1981.
2. Walzer, A. and Koenigsberg, M.: Prenatal Evaluation of Partial Obstruction of Urinary Tract. Radiology 135:93-94, 1980.
3. Lawson, T.L.; Foley, W.D.; Berland, L.L., et al: Ultrasonic Evaluation of Fetal Kidneys, Radiology 138:153-156, 1981.
4. Chopra, A. and Teele, R.L.: Hydronephrosis in Children: Narrowing the Differential Diagnosis with Ultrasound, J. Clin. Ultrasound 8:473-478, 1980.
5. Lebowitz, R.L. and Griscom, N.T.: Neonatal Hydronephrosis: 146 Cases, Radiol. Clin. N. Am. 15:49-59, 1977.
6. Gilsanz, V.; Miller, J.H. and Reid, B.S.: Ultrasonic Characteristics of Posterior Urethral Valves, Radiology 145:143-145, 1982.
7. Markle, B.M. and Potter, B.M.: Surgical Diseases of Urinary Tract, Clin. Diagnostic Ultrasound 8:135-164, 1981.

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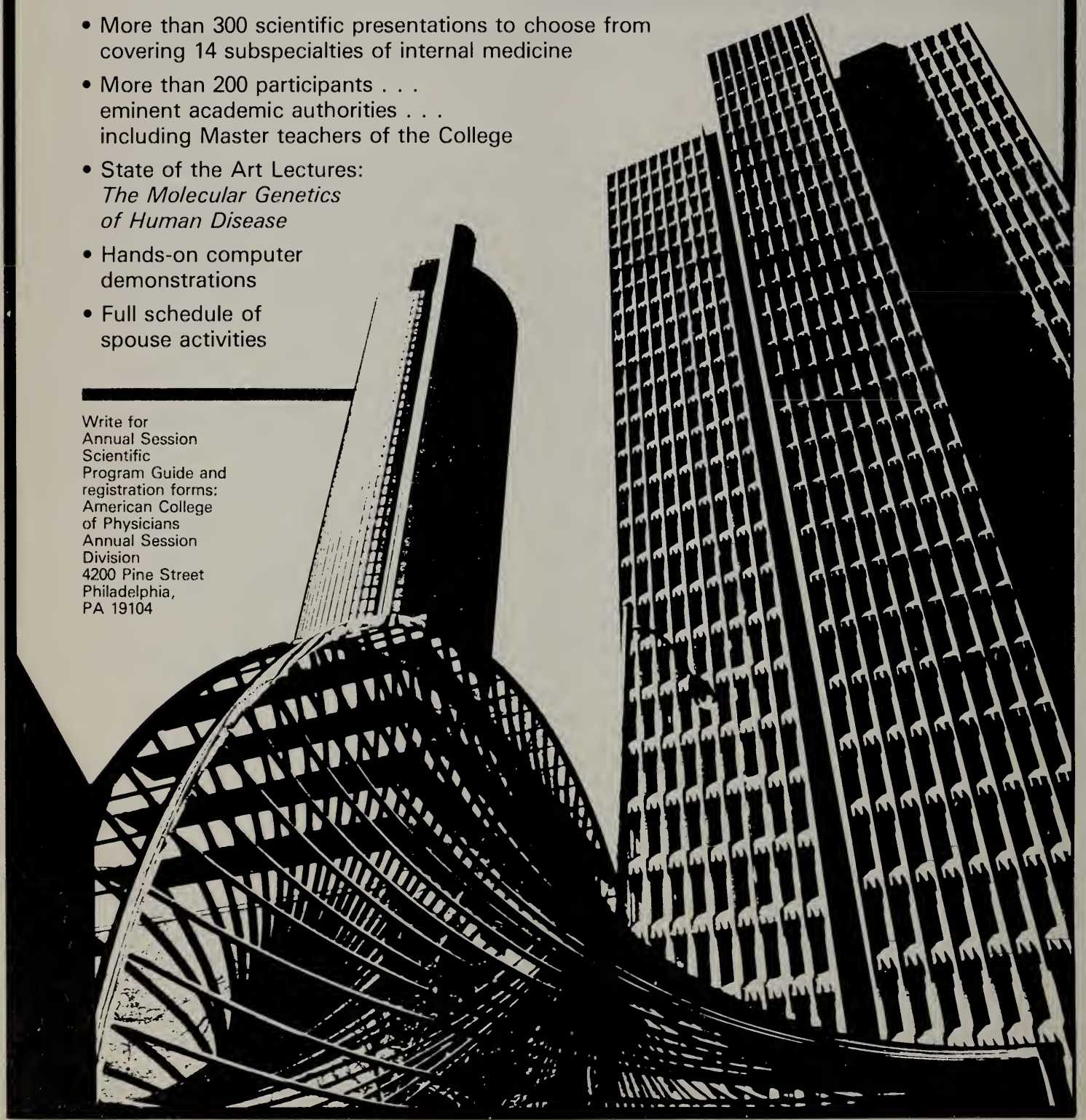
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D-3
February 17, 1984

MEMORANDUM

TO: All Florida Medical Association Members and
Florida Medical Association Auxiliary Members

FROM: J. Lee Dockery, M.D., President

RE: Statewide Florida Medical Association Membership
Teleconference on Professional Liability, March 8, 1984

The Florida Medical Association will conduct an important statewide Teleconference on the FMA's professional liability program on Thursday, March 8, from 8:00 p.m. to 9:15 p.m. EST (7:00 to 8:15 p.m. CST). All FMA members and FMA Auxiliary members are urged to participate in this important meeting.

The purpose of the Teleconference is to report to you on the actions of the FMA House of Delegates at the special Called Meeting on January 28 regarding the Association's future efforts to resolve the continuing professional liability crisis in Florida. Each FMA member has previously received a letter from me dated January 31, 1984 outlining the actions of the House regarding the report and recommendations of the FMA Board of Governors, and a request that each of you actively participate in the implementation of the professional liability program unanimously approved by the House of Delegates.

In determining FMA's future course, the House of Delegates received a comprehensive and detailed report covering all aspects of this complex and difficult issue. My only regret is that all FMA members who are so vital to our future success were unable to be present. The Teleconference has been arranged so that the information presented to the House of Delegates can also be transmitted to as many of the members of the FMA as possible. While we will be limited by time, the presentations will be the same as those presented to the House of Delegates.

The Teleconference will be presented live, originating in Tallahassee, and will be transmitted by satellite to locations throughout Florida which have the necessary equipment to receive the program. On the reverse side is a listing of the cities in Florida where the conference will be telecast. The exact locations where the Teleconference may be viewed are being finalized and we will advise you of the site in your area in a separate memorandum. It is regrettable that the program cannot be viewed in virtually every community in the state, but every effort has been made to establish locations in those cities that will enable the greatest possible number of FMA members and Auxilians to participate.

-more-

Regardless of the location of the meeting in your area, I hope that you will make a special effort to attend so that you will have a clear understanding of the FMA's professional liability program and the importance of the commitment that all of us must make to achieve its success. Participants in the program will include:

Dr. Frank C. Coleman, President-Elect
Dr. Robert E. Windom, Immediate Past President
Dr. T. Byron Thames, Past President & Chairman
Committee on Professional Liability

FMA Consultants:
Senator Lew Brantley, Legislative Consultant
Senator Mallory Horne, Legislative Consultant
Mr. Roy Pfautch, Public Relations Consultant

The FMA is vigorously continuing its efforts on your behalf and the citizens of Florida to resolve on a long-term basis the professional liability crisis in our state which worsens daily. Your elected officers, Board of Governors and representatives in the House of Delegates have made a total commitment to these efforts. However, we cannot do it alone. As stated in my letter to you on January 31, I firmly believe our greatest successes result from our most difficult tasks. Together and united we will succeed in this noble cause.

Sincerely,

Lee Dockery

J. Lee Dockery, M.D.
President

Florida Medical Association, Inc.
Teleconference
Thursday, March 8, 1984
Cities and Locations
for Viewing

The FMA Teleconference will be held in the following cities. We will advise you of the conference site in your area in a separate memorandum.

Bradenton
Cocoa Beach
Daytona
Ft. Lauderdale
Ft. Myers
Gainesville
Jacksonville
Lakeland
Miami
Ocala
Orlando
Panama City
Pensacola
Sarasota
St. Petersburg
Tallahassee
Tampa
Vero Beach
West Palm Beach

Proceedings
Called Meeting
Florida Medical Association
House of Delegates
Jacksonville, January 28, 1984

The special Called Meeting of the House of Delegates was called to order at 10:15 a.m. on Saturday, January 28, 1984, at the Sheraton at St. John's Place, Jacksonville, Florida, by Dr. James B. Perry, Speaker.

The House was invited to stand for the singing of the Star Spangled Banner and the Pledge of Allegiance to the Flag, and remain standing for the invocation.

Dr. Perry announced the membership of the Credentials Committee:

Fred S. Carter, M.D.
Robert E. McCammon, M.D.
Margaret C.S. Skinner, M.D.

The Delegates were reminded that they must register with the Credentials Committee before this meeting of the House of Delegates.

Dr. Carter, Chairman of the Credentials Committee, announced that 209 Delegates were present, representing 39 component county medical societies, which constitutes a quorum.

A motion carried to seat the Delegates. A motion was also carried to adopt the Rules and Order of Business and to have the House as a whole sit as the Reference Committee.

Delegates

ALACHUA—O. Frank Agee, M.D.; Mark V. Barrow, M.D.; William B. Deal, M.D.; Charles P. Gibbs, M.D.; William T. Hawkins, M.D.; D. Orvin Jenkins, M.D.; Gerold L. Schiebler, M.D.; Mr. James B. Dolan, Student.

BAY—James T. Cook III, M.D.; B. Philip Cotton, M.D.; John F. Mason Jr., M.D.

BREVARD—Hani M. Agrama, M.D.; Raymond A. Armstrong, M.D.; Walter A. Cerrato, M.D.; Howard W. Pettengill, M.D.; Paul J. Popovich, M.D.; Ovidio E. Vitas, M.D.; Joseph C. Von Thron, M.D.

BROWARD—Bruce B. Burgess, M.D.; Walter A. Campbell, M.D.; Andre S. Capi, M.D.; George J. Crane, M.D.; David A. D'Alessandro, M.D.; Arthur L. Eberly Jr., M.D.; Paul A. Flaten, M.D.; Theodore W. Hahn, M.D.; William C. Hartley, M.D.; Wilbur F. Helmus, M.D.; James A. Jordan, M.D.; David C. Lane, M.D.; Jerry D. Moore, M.D.; Ernest G. Sayfie, M.D.; Herbert M. Todd, M.D.; Juan S.A. Wester, M.D.

CAPITAL—Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Robert N. Webster, M.D.

CHARLOTTE—Joseph R. Goggin, M.D.

CITRUS—W. Randall Jenkins, M.D.

CLAY—Absent

COLUMBIA—Umesh M. Mhatre, M.D.

COLLIER—Charles S. Eytel, M.D.; Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.

DADE—Edward R. Annis, M.D.; Jerome Benson, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Richard J. Feinstein, M.D.; M. Felix Freshwater, M.D.; Joseph Harris, M.D.; James J. Hutson, M.D.; Norman M. Kenyon, M.D.; Jesse G. Keshin, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Morton L. Miller, M.D.; Dolores A. Morgan, M.D.; Sheldon D. Munach, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Edward L. Reid, M.D.; Oscar Sandoval, M.D.; Arnold F. Schild, M.D.; Daniel L. Seckinger, M.D.; Margaret C.S. Skinner, M.D.; Marvin B. Slotkin, M.D.; Samuel P. Stokley, M.D.; Rodney L. Teichner, M.D.; John C. Turner, M.D.; Harold H. Weiner, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.

DESOTO-HARDEE-GLADES—Absent

DUVAL—Harvey E. Bernhardt, M.D.; Clyde M. Collins, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Emmet F. Ferguson Jr., M.D.; William J. Garoni Jr., M.D.; Walter A. Harmon, M.D.; Charles P. Hayes Jr., M.D.; Howard P. Hogshead, M.D.; John F. Lovejoy Jr., M.D.; William Z. McLear III, M.D.; Kevin M. McAuliffe, M.D.; Charles B. McIntosh, M.D.; Faris S. Monsour, M.D.; Sanford A. Mullen, M.D.; James G.T. Nealis, M.D.; Guy T. Selander, M.D.; Robert H. Threlkel, M.D.; James W. Walker, M.D.; W. Donald Walklett, M.D.

ESCAMBIA—Richard H. Ciordia, M.D.; John W. Garner, M.D.; Charles J. Kahn, M.D.; Theodore J. Marshall, M.D.; Michael R. Redmond, M.D.; F. Norman Vickers, M.D.

FLAGLER—Absent

FRANKLIN-GULF—Joseph P. Hendrix, M.D.

HERNANDO—C.J. McGrew Jr., M.D.

HIGHLANDS—Luis M. Pena, M.D.

HILLSBOROUGH—Richard A. Bagby, M.D.; William T. Branch, M.D.; Frank C. Coleman, M.D.; John C. Fletcher, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Robert E. McCammon, M.D.; Thomas E. McKell, M.D.; Gerold L. Stoker, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D.

INDIAN RIVER—Donald L. Ames, M.D.; Paul A. Graham, M.D.; Michael B. Zimmer, M.D.

LAKE—Joseph E. Holland, M.D.; Robert H. Hux, M.D.

LEE—Larry P. Garrett, M.D.; Quillian Jones Jr., M.D.; Douglas A. Newland, M.D.; Stephen R. Zellner, M.D.

MADISON—Michael O. Stick, M.D.

MANATEE—Thomas R. Busard, M.D.; David F. Gouwens, M.D.; James T. Rogers Jr., M.D.

MARION—James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.; Frank Wilkerson, M.D.

MARTIN—Fred S. Carter, M.D.

MONROE—Absent

NASSAU—Jose L. Castillo, M.D.

OKALOOSA—William W. Thompson, M.D.

ORANGE—Cesar Baro, M.D.; Francis M. Coy, M.D.; Wayne L. Godbold, M.D.; W. Edward Hoffmeister, M.D.; Joseph G. Matthews, M.D.; Jimmie D. Moore, M.D.; Louis C. Murray, M.D.; Charles T. Price, M.D.; James F. Richards Jr., M.D.; Robert N. Serros, M.D.; Edward W. Stoner, M.D.; Robert B. Trumbo, M.D.

OSCEOLA—Gilberto Perez, M.D.

PALM BEACH—Vernon B. Astler, M.D.; E. Joan Barice, M.D.; McKinley Cheshire, M.D.; Lee A. Fischer, M.D.; J. Russell Forlaw, M.D.; James M. Johnson, M.D.; V.A. Marks, M.D.; Nicholas S. Petkas, M.D.; James F. Smith, M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D.

PANHANDLE—Herbert E. Brooks, M.D.; James T. Cook Jr., M.D.

PASCO—Harvey O. Kaiser, M.D.; Robert D. May, M.D.; Ross G. Olson, M.D.

PINELLAS—William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; John M. Hamilton, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; William F. Mallette, M.D.; Jack A. MaCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Howard L. Reese, M.D.; William H. Schmid, M.D.; Walter H. Winchester, M.D.

POLK—Annette C. Barnes, M.D.; Raymond F. Barnes, M.D.; Ronald W. Case, M.D.; Thomas M. Caswall, M.D.; S. Bruce Gerber, M.D.; John W. Glotfelty, M.D.; Thomas E. McMicken, M.D.; John C. Moore, M.D.

PUTNAM—Roy E. Campbell, M.D.

ST. LUCIE-OKEECHOBEE—Khalil A. Cassimally, M.D.; David L. Fromang, M.D.; William H. Meyer Jr., M.D.

SANTA ROSA—Absent

SARASOTA—John N. Carlson, M.D.; Kenneth C. Kiehl, M.D.; Martin F. Mihm, M.D.; Douglas R. Murphy, M.D.; Franklin H. Pfeiffenberger, M.D.; Richard C. Rehmeyer, M.D.; Karl R. Rolls, M.D.; David L. Thomas, M.D.

SEMINOLE—Orlando Garcia-Piedra, M.D.; Luis M. Perez, M.D.

SUWANNEE-HAMILTON-LAFAYETTE—NONE

TAYLOR—John A. Dyal, M.D.

VOLUSIA—Martin S. Feigenbaum, M.D.; Robert W. Lankford, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Roger Lewis, M.D.

WALTON—Absent

WASHINGTON—Absent

SPEAKER OF THE HOUSE—James B. Perry, M.D.

The Speaker introduced the individuals at the Speaker's Table: Dr. Robert E. Windom, Immediate Past President; Dr. James G. White, Vice President; Dr. Frank C. Coleman, President-Elect; Dr. Luis M. Perez, Secretary; Dr. Yank D. Coble Jr., Treasurer; Dr. W. Harold Parham, Executive Vice President; and Dr. J. Lee Dockery, President.

Remarks — Speaker of the House

Before we begin, I think it is only appropriate that the Speaker give you some idea of how we are going to act today and what we are going to do. We are here today to deliberate a number of solutions proposed by the Board to resolve the continuing professional liability insurance problem and its immediate tangential ramifications. In the order of business, the President will introduce various individuals who will present to you background information in their area of expertise. This information will have to be taken as a whole, assimilated, and collated by each of you to have a better understanding of the problem, its seriousness and its potential solutions. After these individuals have given you their reports, the Speaker will open the floor for questions to any presenter or member of the Board. At that time, anyone in the Florida Medical Association will be given the opportunity to speak. This will include delegates and anyone with the privilege of the floor. Of course any member of the Association may also speak. This House of Delegates, as you have voted, are acting as a Reference Committee of the whole, and you may ask questions of anyone that you so desire. In order to give everyone a chance to be heard, debate will be limited. However, if in the Speaker's judgement or if the desires of the House mitigate, the time limit will be extended. Since the entire House is sitting as a Reference Committee, it is only appropriate that they have a chance to caucus as county delegations or as individual groups. At the buffet lunch break, you will be encouraged to sit with your own colleagues in order to informally or formally, discuss the proceedings and decide if meaningful amendments to the main motions will be engendered by you, the Reference Committee. Any amendment should be written and brought before the House as a report from your section of the Reference Committee. Each item brought before the House will be handled and disposed of in the most positive way possible before proceeding to the next issue or matter to be discussed. This is after we come back in the afternoon session. In the absence of our Vice Speaker, Dr. Frank McKechnie, Dr. Charles Donegan, Chairman of the AMA Delegation of the Florida Medical Association and a former Speaker of this House, will act as Parliamentarian should his expertise be needed. We do not want too many amendments clouding the major resolutions under consideration. Following the resolution of the primary problem, the Speaker may request the House's indulgence to bring some needed bylaw changes to the floor for consideration prior to adjournment. At 3:00 p.m., if the House of Delegates has their business completed, the leadership portion of the meeting started on Friday afternoon will continue. Of course, everyone is urged to participate in this section, also. At this point, I should like to have our President, Dr. J. Lee Dockery, who has been under a tremendous amount of strain, has gone to a great number of meetings, and has put together a fantastic program and has led us truly as a President should, come forth and preside over the next portion of this meeting. I have asked that Dr. Dockery, as Chairman of the Board of Governors, present the report and recommendations of the Board. Each recommendation will be discussed with presentations by the appropriate FMA representatives and FMA legislators and public relations consultants.

Remarks of the President

Mr. Speaker, Officers, members of the Board of Governors, members of the House of Delegates, guests, ladies and gentlemen. I am honored to be here; however, when I agreed to accept this role, it followed Dr. Windom, who did such a fantastic job. Turmoil and tribulation have gone on in his year as President as well as in mine — how lucky can you get, to always be at the wrong place at the wrong time. That is the way my life has been lately. This is not the year to be President of this Association. Dr. Windom worked very, very hard, represented you exceedingly well, met with over 23 journal committee publications throughout the state, met with legislative leaders, and other members of the Florida Medical Association, all of which was for naught, because we were nôt successful in solving the professional liability problem last year. You will recall at the 1983 Annual Meeting, we did not conclude deliberations on the professional liability issue and the Legislature was still in session. At that time we did not know the outcome of the Session when we left our meeting on May 8. All of it is now history. We were not successful. We got nothing through the Legislature. The Senate, of course, was very supportive and reaffirmed their support repeatedly throughout the Legislative Session, but we could not even get the issue considered by the House of Representatives. We met at the Post Convention Board Meeting, and I would like to take you through some of the chronology that has been going on this year — to this moment — to help you deliberate the issue before you today.

Let me say at first and you will hopefully remember throughout the day, we must enter into these deliberations, decisions and considerations from the heart, with the desire to do what is best for this Association. I would ask that you not consider this issue as to whether it is voting for or against me, whether it is voting for or against the Board of Governors' recommendations; but what is truly best for this Association and the patients that are served by the members of this Association. And I have every confidence that you will be able to deliberate in this manner.

Dr. Dockery said that the purpose of the presentations was to apprise the House of the chronology of the 1983 Legislative Session leading to the report and recommendations of the Board of Governors that are before the House.

Dr. Dockery advised the House that he had requested and received approval from the Speaker to have the FMA's legislative consultants, Senator Mallory Horne and Senator Lew Brantley, report to the House on their evaluation of the 1983 Legislative Session and their perception of the FMA's future legislative activities and alternative approaches. He indicated that Mr. Roy Pfautch, Public Relations Consultant, had also been requested to report to the House on the Public Opinion Survey that his firm, Civic Service, Inc. had conducted for the Association in September 1983 to measure public opinion regarding health care in Florida and the professional liability issue and the potential support for a constitutional initiative on tort reform.

Dr. Dockery reviewed the Association's activities since the 1983 Legislative Session.

The Board of Governors at its meeting in June, reviewed the actions of the 1983 Legislature and carefully evaluated the Association's future activities in resolving the professional liability problem. The House of Delegates and the Board of Governors, on behalf of the physicians of Florida and the patients they serve, determined that resolution of the professional liability crisis shall remain a top priority.

The Board, in addition to the analysis of the actions of the 1983 Legislature, considered the feasibility of reintroducing legislation during the 1984 Session. The Board requested that the FMA Executive Committee meet jointly with the Committee on Professional Liability and the Association's legislative consultants to conduct an indepth analysis of the actions of the 1983 Legislature on the FMA tort reform proposals and to submit recommendations to the Board regarding the Association's future activities in resolving the professional liability problem.

The Board further requested that a public opinion survey be conducted among registered voters in the state of Florida by FMA Public Relations Consultant, Mr. Roy Pfautch of Civic Service, Inc., St. Louis, Missouri. The purpose of the survey was to measure the potential for public support of alternative initiatives in addressing the professional liability problem outside the legislative process.

Dr. Dockery then called on Mr. Pfautch to present his report on the results of that survey.

While Mr. Pfautch approached the podium, the Speaker took the opportunity to recognize distinguished guests at the meeting. He proceeded to recognize Dr. Joseph F. Boyle, President-Elect of the American Medical Association, from California; Mrs. Priscilla Gerber, President of the Florida Medical Association Auxiliary; and Mrs. Nancy Smith, President-Elect of the Florida Medical Association Auxiliary.

Mr. Pfautch began by saying his company, Civic Service, Inc., has been privileged to work with the Association for a number of years in exploring the attitudes of Florida citizens toward the medical profession. Most recently, his company conducted a survey to determine the image of physicians and health care within the state and to measure the potential for public support for a constitutional initiative on tort reform to be included on the November 1984 General Election ballot. He emphasized that the results of the survey only indicate the climate at the time of the survey and by no means guarantees that the same opinions would prevail if a poll were taken today or in the future. However, the survey reflects strong public support for constitutional revision provided it is presented in the proper form.

Mr. Pfautch then outlined the survey including the nature of the research and the findings.

Nature of Research

- Voter sentiment was expressed in a statewide opinion survey conducted in September 1983, throughout Florida through a

series of over 500 person-to-person, in-home interviews designed to determine public feeling about health care in the state of Florida and voter attitudes toward needed reforms in Florida's tort (civil litigation) system to insure the continuance of high quality care.

- The survey, designed and implemented by an independent research organization, included 550 voting-age Floridians representing all major areas of the state as well as a major cross section of occupational, age, political party and other demographic factors. The methodology produced a sample which has a confidence value of 5 percent at the 95th interval, which means that if 100 similar surveys were conducted in a similar fashion, 95 would produce the same results with a 5 percent error possibility.

Public Understanding and Perception of Professional Liability Issue

- The data illustrates that the people of Florida are aware of the problems created by the professional liability crisis regarding availability of quality health care and rising costs that the consumer must ultimately pay.
- The widespread understanding of the malpractice crisis evident among those interviewed, obviously was furthered by intensive media coverage in recent years of million dollar suits. The survey indicated that most Floridians believe there should be a limit on the amount of such awards and that the average family pays higher medical costs because of such settlements. Over 68 percent of those polled believe there should be a limit on malpractice suit awards.
- Nearly 75 percent, which is three out of every four respondents, feel that such suits cost the public, and a similar group view these suits as "threatening health care in Florida."

Findings of Research

- The overwhelming majority of those interviewed believe that the public initiative approach is a proper way in which to enact constitutional changes. Nearly 85 percent support such procedure.
- Clearly, the public believes that the public initiative is a right to which the public is entitled. Opponents of the public initiative approach will face major public opposition. One respondent asked, "Do they want to deny the people their ultimate rights?"
- The survey reflects that the voters of Florida currently favor the basic propositions contained in the proposed constitutional amendments developed by the Florida Medical Association to continue the high levels of health care delivery and health care availability presently the standard in Florida.

  Over 70 percent of those interviewed believe that judges should have the right "to dismiss a case without trial if the judge determines that a suit is brought without merit."

  Nearly 75 percent of the voting age respondents agree "that in any law suit an individual's liability is only limited to his part of the case."

  Finally, 60 percent endorse "limiting damages in a malpractice case to the economic loss of an individual."

- The initial strong support for the constitutional amendments needs to be encouraged during the forthcoming constitutional initiative campaign approved by its FMA House of Delegates as doubtless there will be attempts to distort and confuse the basic constitutional issues. The key to the success of the initiative is to present the fundamental facts on each proposal, confident that the public wants something done to solve the problem. At present, the public knows there is a crisis and that the crisis is costing the people money and threatening the quality and access to health care. They see the solutions proposed in the constitutional reform package as strong steps to correct the system.

The Constitutional Initiative

- The campaign to bring about positive and equitable reform in Florida's tort system begins with strong public support. Clearly, the key to success will be to sustain strong public support and avoid those controversies which could cloud the issue.
- The findings of the survey do not guarantee success at the polls in November 1984. It does clearly reveal that there are grounds for change which the public supports and where the public wants action. Our task is to be in concert with the public on election day!
- The challenge ahead is to make certain that every possible voter throughout the state understands that the constitutional tort reforms proposed by the FMA will serve the best interest of citizens throughout the state and provide the constructive, positive solutions the public so clearly indicates through the survey that they wish to become a part of our Florida Constitution.

The President introduced Dr. T. Byron Thames, Chairman of the Committee on Professional Liability.

Remarks of T. Byron Thames, M.D.
Chairman
Committee on Professional Liability

For the past three years I have had the honor to serve as Chairman of the Professional Liability Committee. The Committee has studied and worked on the problem of Professional Liability which is the business of the House today. We have met with many groups, including Justices of the Supreme Court, Representatives of the Trial Bar, and Defense Attorneys, legislative leaders and our own consultants. We have also met with citizen groups from the Florida Chapter of the American Association of Retired Persons, the Railroad Industry, and other businesses. We have met with citizen forums on a special committee for the Insurance Commissioner's office and with members of the Legislature. We have received support from the Florida Senate in our efforts to do something legislatively about the Professional Liability issue. We have also communicated closely with the Governor and his staff. We have thoroughly explored the issues through the media and through debates with Attorneys. I do not wish to express personal feelings at this time, but simply want to provide you with a background of what the Professional Liability Committee has done and has recommended to your Board of Governors.

One approach to the problem is to continue to work through the Legislature even though we have been unsuccessful so far. A second approach is to attempt constitutional revision. A third approach not yet mentioned is the development of an insurance program (often referred to as Hospital Trip insurance) which would protect the hospital, the physician, and the patient against adverse results during hospitalization. The Committee has tried to look at each approach and has shared its ideas with the Board of Governors. The Committee feels that the Board has attempted to develop the solutions that hold the best chances of success. We must educate the public on the Professional Liability problem which affects all of us not only in terms of cost, but also in emotional trauma and our ability to serve our patients.

The President then introduced Senator Lew Brantley, a former President of the Senate and member of the House of Representatives. Senator Brantley advised that the experience of the 1983 Session and a careful evaluation of the 1984 Legislature left little hope that the Association could achieve any substantive tort reform. The current House Speaker, Lee Moffitt, who will also serve during the 1984 Session seems totally unwilling to address major tort reform and the next Speaker has not taken a position. Senator Brantley said that in spite of the current environment in the House, he felt that we should not abandon the legislative approach but instead should undertake two methods, one being continuation of the legislative process and the other being to take the public route through a constitutional initiative campaign. Senator Brantley indicated that he did not feel that the constitutional initiative posed any serious implications for the Association's future legislative activities.

The President then introduced Senator Mallory Horne, former President of the Senate and Speaker of the House of Representatives. Senator Horne expressed his agreement with the remarks made by Senator Brantley as to the current political climate in the House of Representatives and the unlikelihood of achieving effective tort reform during the 1984 Session. He supported, however, a joint approach expressing the view that the constitutional initiative approach held the greatest potential for success. He warned, however, that if the constitutional approach is chosen that it must be approached in a totally unified effort if it is to succeed.

Following these presentations, Dr. Dockery reviewed each of the recommendations adopted by the Board of Governors at its meeting in October 1983 for presentation to the House of Delegates.

The Speaker then invited all delegates and other FMA members present to direct questions and comments to the Chair and Dr. Dockery regarding each of the proposals.

The first meeting of the House of Delegates was recessed at approximately 12:15 p.m.

The second meeting of the House of Delegates convened at 2:15 p.m. Two hundred nine Delegates, representing 39 component county medical societies, were present constituting a quorum.

A motion was made and seconded to adopt the report and recommendations of the Board of Governors. This was followed by an indepth debate on each of the Board's recommendations.

With regard to Recommendation No. 1 regarding the elimination or limitation on non-economic damages, a motion to delete the word "eliminate" was defeated.

There was also a discussion regarding Recommendation No. 3 regarding the amount of the assessment to implement the professional liability program. The House deliberated several recommendations increasing the amount of the assessment from the $200 recommended by the Board.

A motion was made and passed to amend Recommendation No. 3 to require an assessment of all FMA active members in 1984 in the amount of $300.

A motion was made and seconded and passed unanimously to adopt the report and recommendations of the Board of Governors regarding professional liability as amended.

Report of the Board of Governors

RECOMMENDATION NO. 1

TO HAVE PLACED ON THE BALLOT FOR THE NOVEMBER 1984 GENERAL ELECTION IN FLORIDA PROPOSALS FOR AMENDMENT TO FLORIDA'S CONSTITUTION AFFECTING ALL CIVIL LITIGATION, TO INCLUDE THE FOLLOWING CONCEPTS:

(the exact clarifying language to be determined)

SUMMARY JUDGMENTS — IN A CIVIL ACTION, A COURT SHALL, ON THE MOTION OF THE DEFENDANT OR PLAINTIFF, GRANT A SUMMARY JUDGMENT IF THE COURT FINDS NO GENUINE DISPUTE EXISTS CONCERNING THE MATERIAL FACTS OF THE CASE;

ELIMINATION OR LIMITATIONS ON NON-ECONOMIC DAMAGES — ELIMINATES OR LIMITS THE RECOVERY OF NON-ECONOMIC DAMAGES FOR PAIN AND SUFFERING AND OTHER LOSSES SUCH AS MENTAL ANGUISH AND LOSS OF CAPACITY FOR ENJOYMENT OF LIFE;

ELIMINATION OF JOINT AND SEVERAL LIABILITY — IN A CIVIL ACTION, NO DEFENDANT SHALL BE RESPONSIBLE FOR PAYMENT OF DAMAGES IN EXCESS OF HIS/HER PERCENTAGE OF LIABILITY.

RECOMMENDATION NO. 2

THAT THE FMA MAINTAIN A LEGISLATIVE POSTURE RELATIVE TO TORT REFORM AND THAT ANY PROPOSED LEGISLATION EMBODY THE SAME PRINCIPLES PROPOSED TO THE PUBLIC FOR CONSTITUTIONAL REVISION INCLUDING SUMMARY JUDGMENTS, ELIMINATION OR LIMITATIONS ON NON-ECONOMIC DAMAGES AND THE ELIMINATION OF JOINT AND SEVERAL LIABILITY.

RECOMMENDATION NO. 3

EACH FMA ACTIVE MEMBER WILL BE REQUIRED TO PAY A MANDATORY ASSESSMENT OF $300.00 FOR 1984, IN ADDITION TO ALL CURRENT FMA DUES AND FEES, TO BE UTILIZED IN IMPLEMENTING THE PROFESSIONAL LIABILITY PROGRAM APPROVED BY THE HOUSE OF DELEGATES, AND THE FMA BOARD OF GOVERNORS SHALL SET AN APPROPRIATE DUE DATE FOR PAYMENT OF THE ASSESSMENT.

RECOMMENDATION NO. 4

THE HOUSE OF DELEGATES APPROVE THE CONTINUED STUDY OF THE CONCEPT OF THE HOSPITAL ADMISSIONS INSURANCE PROPOSAL, "NO FAULT CONCEPTS", AND THE PROBLEM OF CONTINGENCY FEES.

RECOMMENDATION NO. 5

RESOLVED THAT THE MEMBERS OF THE HOUSE OF DELEGATES INDIVIDUALLY ASSUME RESPONSIBILITY FOR INFORMING THEIR CONSTITUENTS ABOUT THE NEED TO PARTICIPATE PERSONALLY IN EDUCATING THE PUBLIC ABOUT THE PROFESSIONAL LIABILITY PROBLEM.

Status of Professional Liability in Florida

Since 1975, the FMA has successfully sponsored a number of tort reform proposals designed to resolve the professional liability problem. Unfortunately, many of these proposals have either been declared unconstitutional or have been ignored by the Judiciary. One of the major setbacks was the loss of the mediation panels in February 1980 which were declared unconstitutional by the Florida Supreme Court. Since that time, unprecedented increases in professional liability premiums have resulted. Physicians insured by the Florida Physicians' Insurance Reciprocal (FPIR)* have experienced a 116 percent increase in premiums since the court's decision. This situation is not unique to Florida. Other states which have enacted or sought tort reform legislation have suffered similar problems by either failing in their attempt to have tort reforms enacted or by having existing statutes repealed or declared unconstitutional by the courts.

Juries continue to deliver multi-million dollar awards to plaintiffs which defy all reason, and judges have been reluctant to implement existing statutes in limiting these abuses when awards were clearly excessive. A court in Florida recently awarded $9.25 million in damages in a suit filed against an obstetrician/gynecologist and a hospital where the physician carefully monitored the mother, and there was no medical negligence involved with an abnormal birth.

Physicians in training are becoming reluctant to enter specialty programs which are at a high risk for liability in today's litigious society. Some physicians are discontinuing high risk procedures. A recent survey revealed that 25 percent of the responding obstetricians had stopped practicing obstetrics, citing the professional liability problem as the primary reason. Family physicians are also limiting patient services and increasing the practice of defensive medicine as are other specialists because of the professional liability problem.

In Florida, there are additional efforts to remove any safeguards which may remain in the tort system against frivolous suits and inequitable awards. Legislation has been proposed for the 1984 Legislative Session seeking repeal of the Recovery of Cost Bill which was enacted in 1981. There is also a proposal that would increase the statute of limitations for malpractice suits from two to four years. There would be no overall limit for those situations involving "discovery" issues.

The Florida Physicians' Insurance Reciprocal has experienced a continuing increase in the frequency and severity of claims. Since inception of the program, frequency per 100 physicians has increased 300 percent and severity by 350 percent. At the end of 1982, the FPIR had paid or reserved 436 claims in excess of $100,000. Prior to 1979, there were no claims exceeding $1,000,000. During 1983, there have been 1,420 claims which equal less than one out of each four being sued.

1983 Legislative Session

At the Annual Meeting of the Florida Medical Association in May 1982, the House of Delegates adopted a resolution authorizing a mandatory assessment of $50.00 for all FMA active members for professional liability. Since that time, your Board has given the highest immediate priority to the professional liability problem and adopted a broad-based program entitled, "Reason '83", which included legislative, judicial and constitutional provisions.

During the 1983 Session of the Florida Legislature, the FMA at great expense in money, time and effort sought to have enacted comprehensive tort reform proposals. The Florida Senate overwhelmingly voted in favor of a bill which included many of the Association's proposals. However, the Speaker and leadership of the House of Representatives refused to allow the full House an opportunity to act when there was a prevailing sentiment in the House to adopt the tort reform legislation approved by the Florida Senate.

Constitutional Initiative

Continuously since 1975, the Board of Governors with the untiring assistance of many dedicated physicians and other individuals, has made every effort to bring about through the legislative process, reforms in Florida's tort system that would resolve on a long-term basis the professional liability crisis in our state that is affecting physicians, their patients, and the general public. Despite these efforts, the problem is growing more severe daily and is adversely affecting the access, quality and cost of health care. Your Board feels that in the current climate other alternatives for resolving the professional liability crisis must be considered in addition to the legislative process. One such alternative is through the constitutional initiative process that has proven successful on other issues of public concern in other states. Indeed, the professional liability problem is of public concern. In considering this approach, the Board of Governors requested the FMA's Public Relations Consultant to conduct a public opinion survey among registered voters in the state of Florida to measure the potential public support for a constitutional initiative on tort reform to be included on the November 1984 General Election ballot. This survey was completed and the findings were reported to the Board of Governors in October 1983. This survey revealed overwhelming support by the public for constitutional revision provided it is presented in the proper form.

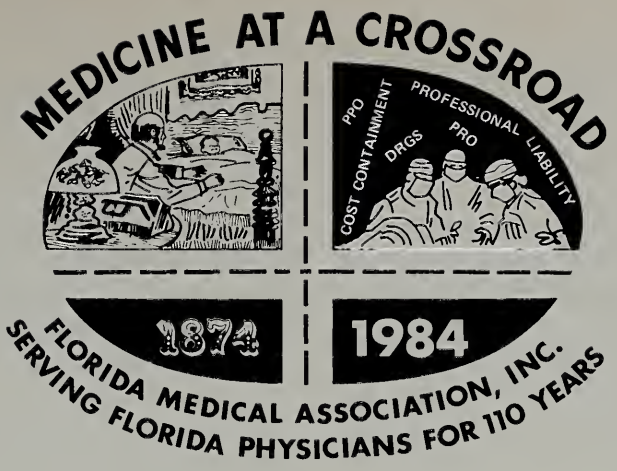
Future Legislative Activities

The Board of Governors continues to consider all options for resolution of the professional liability crisis, including the legislative process. While there is much concern as to the opportunity to have effective measures passed in the Florida House of Representatives during the 1984 Legislative Session, the Board at its meeting in January approved the recommendation of the Council on Legislation that the FMA maintain a legislative posture on tort reform. Bills have been drafted that, if enacted by the Legislature, would embody the same principles proposed for the constitutional initiative.

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*(FPIR) — The Florida Physicians' Insurance Reciprocal is a professional liability program sponsored by the Florida Medical Association.

The special Called Meeting of the House of Delegates adjourned at 3:30 p.m.



Summary
FMA Leadership Conference
January 27-29, 1984
"Medicine at a Crossroad"

Florida's medical leaders were urged last month to establish a cooperative relationship with the media, become active in politics, and knowledgeable about alternate health care delivery systems and new methods of payment.

Experts offered these and many other valuable points of guidance during workshops conducted in conjunction with the 1984 FMA Leadership Conference in Jacksonville, January 27-29. The sessions attracted 389 physicians, spouses and guests to Jacksonville, where the FMA was founded 110 years ago. Forty county medical societies were represented.

The large turnout at this year's Conference was enhanced by a Special Called Meeting of the FMA House of Delegates on Saturday, January 28. The session was called exclusively for determination of the course FMA will take this year toward resolving the professional liability crisis in Florida (see "Proceedings" elsewhere in this issue of *The Journal).*

After the House adjourned on Saturday afternoon, two-hour workshops on Media Relations, Legislation and Medical Economics were conducted. They were repeated the following morning.

Fred Hartmann, Executive Editor of the *Florida Times-Union* and *Jacksonville Journal,* told his listeners at the Media Relations Workshop that reporters often work under a deadline, so a thoughtful but quick response is appreciated. "If you want a few minutes to prepare a 'thoughtful answer' ask for it," he said. "If you don't know the answer, direct the reporter to someone who does. But be honest!"

Howard W. Kelley, Jr., the Vice President and General Manager of WTLV-Channel 12 of Jacksonville, explained that offensive public relations — anticipating questions and having answers ready as well as going to the media with current developments — is often more effective than defensive public relations, or waiting for the media to come to you.

FMA Media Relations Consultant Hank Drane explained that if a reporter cannot find someone in the profession to answer his questions, he may assume physicians have something to hide. The reporter may go somewhere else to have his questions answered, and the physicians' viewpoint may not be well represented. "Don't pick a fight with the media," Drane warned, "and be helpful."

Sanford A. Mullen, M.D., a Past President of both the Duval County Medical Society and the FMA, echoed the need for honesty in dealing with the media. Emphasizing the fact that cooperation with the media can dispel rumors, Dr. Mullen explained that one must meet the media and develop a relationship before a crisis develops in order to be fairly represented.

"Misconceptions of (medical and media) professions have stood in the way of a good working relationship," Paula Horvath, medical reporter for *The Gainesville Sun,* explained. The images of a forked-tongued, sticky-fingered reporter who hounds medical sources and of a close-mouthed, two-faced medical service who uses blanket excuses to keep from giving information are false. Yet, by not keeping the lines of communication between the media and the medical society open, these images are kept alive. She suggested that the media be invited to monthly society meetings.

The speakers at the Legislative Workshop emphasized the need for physicians to be active in their political dealings. Former State Senate President Lewis B. Brantley spoke on the need to be active,

while State Representative Tom Gallagher told listeners to know the politician they are talking to and the subject being talked about. Afterwards, they performed several skits illustrating the very things they had discussed.

Mr. Donald S. Fraser, FMA Associate Executive Director of Legislation, said Medicine's score in the 1984 Legislature will depend on how well the physicians have established a rapport with the legislators. Ernie Sayfie, M.D., member of the FMA Committee on State Legislation, cautioned that doctors must be strong individually and collectively in the legislative battle coming up.

Charles J. Kahn, M.D., also a member of the FMA Committee on State Legislation, warned that if "we don't do something about the health care cost containment problem, someone will. . ." because the Legislature is determined to regulate health care costs.

John S. Zapp, D.D.S., Director of the Washington Office of the AMA, spoke about the Congressional scene. Issues such as the Baby Doe legislation and mandatory Medicare assignment are the ones to watch, and he emphasized that a poor contact with a Congressman is worse than no contact at all.

Robert E. Windom, M.D., President of the Florida Medical Political Action Committee (FLAMPAC), reviewed FLAMPAC's growing membership, and said that physicians need to support and get to know the legislator at home as well as when the Legislature is in session. James G. White, M.D., Vice President of both FMA and FLAMPAC, explained that the FMA Auxiliary is very important to FLAMPAC's operations.

At the Medical Economics Workshop, listeners learned more about PPOs, DRGs, and PROs. George V. Tangen, M.D., President of the Hennepin County Medical Society in Minnesota, reported that 35 percent of his state's population are enrolled in HMOs. The current trends, he said, stem from a doctor surplus and competition for patients who can choose health care based on price.

Frank J. Primich, M.D., Chairman of the Committee on DRG Evaluation and Comment of the Medical Society of New Jersey, said that after four years in New Jersey, no advantage to DRGs has been demonstrated. DRGs, he warned, will not save costs, but will make physician-hospital relationships adversarial.

"The key to all health delivery systems is effective utilization review," said the President of the American Medical Peer Review Association, Howard Strawcutter, M.D. of North Carolina.

In speaking on cost containment, FMA Past President Richard S. Hodes, M.D., Chairman of the FMA Ad Hoc Committee on the Cost of Health Care, said that "PPOs are surgical — you carve out sections of the medical community." He expressed concern that Florida's Cost Containment Board looks at the cost but not quality of service.

Two top officials of the American Medical Association — President-Elect Joseph F. Boyle, M.D. and Executive Vice President James H. Sammons, M.D. — addressed General Sessions on Saturday and Sunday mornings, respectively.

As a business, Dr. Boyle pointed out, the health care industry is a tremendous success. It has grown over the past 10 years by 70%, employs 7 million people and serves 30 million clients a day. As the nation's second largest industry, it accounts for 10% of the gross national product.

"At the same time, we have become a major concern of government and business and industry, for health care is the largest cost of doing business for many corporations," he said.

"We have become a target because of the cost of providing care," he continued. "When cost becomes a principal concern, there will be dilution of access and quality of care."

With regard to prospective payment, Dr. Boyle said the U.S. House of Representatives has come "very, very close to a line, and if we are behind this line we will forever surrender our rights and our patients rights. . ."

Addressing the Conference Sunday morning, Dr. Sammons, Executive Vice President of the AMA, advised medical leaders not to listen to those who say that nothing is going to happen to medicine in the Washington arena this year because 1984 is an election year.

"Everyone says nothing is going to happen in 1984," Dr. Sammons said. "That's nonsense! We have some real potential problems in 1984. We're the last plum they've got ready to be plucked."

He listed DRGs for doctors, fee limits and mandatory assignments as some of the important issues affecting medicine this year.

Some of the current problems with allied health professions have been enhanced by the actions of physicians themselves, he said.

"We have nurse midwives because doctors quit delivering babies," he said. "Doctors have quit seeing patients after 5 p.m. and send them to the emergency room, where the costs are much higher.

"Nurse midwives, opticians and chiropractors are ready to help. No one has told them they have to work only between 9 and 5."

Dr. Sammons warned the audience that when President Reagan states he is going to cut spending, he intends to do so, and the health care budget will not escape the ax.

FLORIDA MEDICAL

DEPARTMENTS

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NOTES & NEWS

FMA Committee on Medical Education making final plans for 110th Annual Meeting

Twenty-four specialty societies have completed their programs for the scientific portion of the FMA 110th Annual Meeting May 2-6, 1984 at the Palace Hotel, Lake Buena Vista. A wide variety of topics will be scheduled Wednesday, Thursday and Friday afternoons, and all day Saturday. In addition, a symposium addressing "The Health of the Public" will be held Friday morning featuring nationally known speakers. Be on the lookout for next month's issue which will list topics and speakers from each participating specialty.

World famous heart surgeons speak at St. Joseph's Hospital in Tampa

Some of the world's most renown heart surgeons recently spoke at a historical seminar on human and mechanical heart transplantation at Tampa's St. Joseph's Hospital.

The list included Dr. Christiaan Barnard, from Capetown, South Africa, who performed the world's first human heart transplant in 1967; and Dr. Robert Jarvik, inventor of the mechanical heart that kept Barney Clark alive for 112 days. This was the first meeting of the two medical pioneers, and Barnard's "last" lecture on heart transplantation. Last month he retired from his cardiac surgery position at The University of Capetown.

Other speakers at the seminar were: Dr. Stuart Jamieson, head of the heart transplantation service, Stanford University; Dr. Richard Lower, chief of cardiac and thoracic surgery, Medical College of Virginia; and Dr. Bruce Reitz, chief of cardiac surgery, Johns Hopkins University.

The surgeons agreed that tremendous advancements have been made in heart transplantation since Barnard's initial operation. His first patient survived only 18 days, and the second more than 19 months.

Today, nearly 70 percent of heart transplant patients can expect to live five years or more with a better quality of life than they had before surgery, said Barnard. Of patients who survive the crucial three months after surgery, 90% are able to return to work.

Barnard told the 210 doctors who attended the seminar that there are five factors contributing to the improved success of heart transplants — better selection of patients, improved surgical techniques, earlier diagnoses of organ rejection, longer preservation of donor hearts, and better drugs (for controlling the body's rejection of donor organs).

"Patient selection is one of the more important elements in the number of patients who survive," said Lower, who along with Dr. Norman Shumway performed the first transplant in the United States in 1968 at Stanford.

Generally, patients who are candidates for transplantation are those who have irreversible, degenerative heart disease which is untreatable by medical therapy or conventional surgery. Another criterion for selection, said Barnard, is that the patient be less than 50 years old, free of infection and other terminal diseases.

According to Dr. Dennis Pupello, director of cardiovascular surgery at St. Joseph's, and coordinator of the January 14 seminar, heart transplants have proved themselves "for a small, select group of patients" dying of heart disease. "It is no longer considered experimental."

One topic that is still considered experimental and which was discussed at length during the seminar is the mechanical heart.

Jarvik and the team of surgeons at the University of Utah Medical Center are eager to do a second implant, and recently received permission from the university's ethics committee. Jarvik said he expects the next implant will be done within six months and with an improved mechanical heart with stronger valves. He points out that Clark did not die from failure of the mechanical heart, rather from "a cascade of diseases" triggered by his lung condition (emphysema). He said the mechanical heart should have better success in a healthier patient.

Clark's heart was powered by a 375-pound pneumatic air compressor, mounted on a movable cart. This same type of "driver", said Jarvik, will be used on the future patients as well.

"For the artificial heart to become more acceptable it has to be totally implantable," said Barnard. "I don't believe carrying a machine (to drive the heart) will be really applicable."

Jarvik said he is working on that problem and is currently developing an electrohydraulic heart that can be linked to a miniature battery pack the size of a small tape recorder, and worn around the waist. He said in coming years anywhere from 15,000 to 80,000 heart attack victims could be saved by the mechanical heart.

Hepatitis B vaccine recommended by ACP for high risk patients

Persons at high risk of contracting hepatitis B should be vaccinated, the American College of Physicians (ACP) announced in a statement published in the January *Annals of Internal Medicine*.

Issued as a part of the College's Clinical Efficacy Assessment Project (CEAP), the statement covers the safety, efficacy and cost of the hepatitis B vaccine and makes recommendations for its use in clinical practice based on those factors.

Hepatitis B is a serious disease infecting more than 200,000 Americans annually. Of the 600,000 to 800,000 carriers in the United States, each year approximately 25% develop chronic hepatitis and some 4,000 die of cirrhosis. Those at greatest risk of infection include homosexually active males; users of injectable, illicit drugs; institutionalized mentally retarded persons; and health workers. The latter are at particular risk due to their high degree of exposure to blood and blood products and to hepatitis B patients.

A safe, highly effective, licensed vaccine — which consists fo inactived human hepatitis B surface antigen (HBsAg) particles — is available for the prevention of hepatitis B disease. While the vaccine has been shown to reduce infection by 80% to 95% in high-risk populations, "protection approaches 100% for patients who receive the proper dose sequence and who develop the usual antibody responses," according to CEAP Director J. Sanford Schwartz, M.D. There are at this time no known serious, immediate or long-term reactions to the vaccine, he stated, nor are there any known cases of vaccine-transmitted hepatitis B disease.

The College stresses that health care personnel working in areas where hepatitis B infection is highly endemic are at high risk of developing the disease and should be immunized.

Based on present costs, screening to discover persons susceptible to the disease is economical only in population groups with an especially high risk of disease. The vaccine is effective only as a preventive measure; once a person is exposed to the disease, the ACP recommends the use of hepatitis B immune globulin, with the vaccine as an added measure for patients at high risk. Copies of this and other CEAP statements may be obtained from the ACP.

Through the Clinical Efficacy Assessment Project, which is funded by a grant from The John A. Hartford Foundation, the ACP evaluates the effectiveness of nonsurgical medical tests, procedures and therapies and makes recommendations on their appropriate uses to help physicians practice high quality, cost-effective medicine more efficiently.

Founded in 1915, the American College of Physicians represents 57,000 internists, related nonsurgical specialists, and physicians-in-training nationwide. Through rigorous membership requirements, contact with health care officials in government and the private sector, and continuing medical education programs, the ACP works to upgrade the quality of medical care, education and research in the United States.

DEAN'S MESSAGE

The medical curriculum at the University of South Florida

This Dean's page will review briefly the history and development of the curriculum at the University of South Florida College of Medicine. It is appropriate to do so at this time, as there are, now, for the first time, four classes of medical students in this program and the first class to complete the four-year program will graduate this June.

The initial curriculum was a four-year program which began when the Charter Medical School Class entered in the Fall of 1971. Due to various pressures both internal and external, the College initiated a revised three-year program with the class which entered in 1972. This program consisted of three twelve month units, representing a basic science year; a clinical clerkship year; and an elective year. The program was, again, modified after two years so that the first block of time for the basic sciences was expanded to fifteen months and the third block of

time, for electives, was decreased to nine months. Due to the intensity of the three-year program, it was the general feeling of most students and faculty that the program should be increased to four years with time provided for possible research and other enriching experiences.

Thus, in 1979, the decision was reached to modify the medical curriculum, again, and reintroduce the "traditional" four-year program with innovative additions where appropriate. This was set in place for the class which entered in 1980 and is to graduate this year. A great deal of energy and effort was expended by the students and faculty, resulting in the current curriculum. Attention was paid in order to ensure that adequate time was allowed for learning, research, and independent study, to be planned by the student in consultation with his or her faculty advisor.

The program as it now exists includes a number of unique offerings and opportunities. Each year of the program has been tailored to accomplish specific goals. The first year begins in the fall allowing for a summer break prior to the commencement of Medical School. The first year presents the basic offerings of Biochemistry, Anatomy, Physiology, Medical Microbiology, Public Health and Introduction to Physical Diagnosis. In this way, as the student builds basic science knowledge, he or she is introduced to clinical medicine allowing for correlation of early studies with future clinical practice.

The second year presents Pathology, Introduction to Clinical Medicine, Pharmacology, Laboratory Medicine, Physical Diagnosis, Behavioral Medicine and Cross-Sectional Anatomy. This year is designed in such a way as to allow for transition from basic to clinical science as well as the development of an active role for the student in his or her educational process. This course "Cross-sectional Anatomy" deserves special mention. This course was designed to introduce the modern technology of computerized axial tomography and correlate it to traditional anatomy in preparation for the clinical experiences which will follow. The specimens used include axial tomograms and cross-sectional specimens which were produced simultaneously. This course has served as an excellent anatomical review and has provided a substantial base upon which the students have been able to build before entering the clinics.

The third year clinical clerkships are unchanged and include Internal Medicine, Obstetrics and Gynecology, Pediatrics, Psychiatry, and Surgery. The important modification in this year has been the calendar which now allows completion of course work in sequence with other institutions so that decisions for postgraduate training can be made at the appropriate time.

The fourth or elective year was implemented in order to accomplish the following goals:

1. Five months of elective courses.
2. Three months of Primary Care Ambulatory Medicine.
3. One month of Neurologic Science
4. Three months of independent study. This is the period of time during which students may initiate research projects, travel to other schools or enhance their experiences in other ways. Some students have taken courses in the Business College and some have traveled to other parts of the world to observe medical practice in varied socio-economic settings. A written report is required after these rotations. It appears from this first class experience, to date, that this has been a successful endeavor.

The final innovation in the implementation of the elective year is a faculty senior advisor program to assist the student in designing a schedule for the last year as well as planning for postgraduate training.

We are about to begin a thorough review of each year of the program in order to ascertain whether our goals and aims are being achieved. If any changes are necessary, they will be accomplished following this review.

A national study of medical curricula currently is underway entitled "General Professional Education of the Physician" (GPEP). The results of this study will be reported during the coming year. Obviously, if significant changes are recommended, we will be able to accommodate them in our current process, though we feel certain that the curriculum which we have developed is the proper one for our student body. Preliminary reports from the GPEP Commission indicate that several changes similar to our "innovations" will be recommended to medical schools at large. The educational experience appears to be an excellent one and provides a solid foundation for future training and practice.

James A. Hollack, M.D., Deputy Dean
Univ. of South Florida College of Medicine

CORRESPONDENCE

Consideration for the retired physician — a plea!

Dear Editor: Many senior physician doctors from the northeast and midwest have migrated to the south and settled in the cities of Florida's east and west coasts. After an exhaustive practice of 30 or 40

years they have come with high hopes and expect to enjoy the fruits of lifelong labors in sweet retirement in a pleasant climate.

Sooner or later, however, they are beset by many of the health problems they have solved or helped to solve for others in the course of their professional life. They find themselves obliged to spend an ever-increasing part of their energies in maintaining or regaining their own or the health of their spouses. They are forced to acknowledge that the ravages of advancing years or illnesses do not stop because they are doctors.

In trying to cope, the retired physician encounters frustrations that are very irritating if he happens to be a sensitive doctor. It can be severe enough to aggravate the organic component of his disease to a considerable degree.

Coming from an era of "Professional Courtesy" and "Peer Consideration" within the family-like professional community where he practised, the retired physician often finds that courtesy and consideration, as he knew it, is a thing of the past.

It is not even a matter of money! Like other Senior Citizens, the retired doctor is covered by Medicare and supplementary insurance that well remunerate the attending physician if he accepts assignment.

The frustrations of the retired doctor-patient are procedural and substantive. Among the procedural irritations are the need to fill out lenghty forms, sit for prolonged times in a crowded waiting room and await his turn, sweat it out till the next visit to get the result of an acid phosphatase test or biopsy. In days gone by the attending physician would have personally called as soon as the result was known.

Most upsetting is the need to deal with the attending physician, usually a much younger man, through a protecting wall of "girls" who seem to have taken over the doctor part in the vaunted patient-doctor relationship.

Of potentially grave consequence are more substantive matters such as a feeling that the diagnosis made is faulty, that symptoms described to the attending physician have been ignored or made light of. This makes the retired doctor feel that because of his age and new status he is now expendable.

These grievances, even if petty to some, increase the trauma of retirement.

As it often happens, instead of trying to understand the older man, the attending physician becomes annoyed with questions and doubts. He is usually a very well trained, board-certified practitioner who cannot be expected to play the sleuth, go out of his way to unearth and sublimate nuances of symptoms of an ordinary prostate or cardiac condition. He feels that the nuances are marginal and need no further discussion.

The end result of all this can be quite damaging. When told again and again "not to be his own doctor" the doctor-patient is overcome by feelings of helplessness, hopelessness, anxiety and eventual depression.

In the Fort Lauderdale area with the generous help and cooperation of one of the most prestigious hospitals in the community,* the retired physician have formed The Senior Physicians Associates to help confront their problems.

The hospital has endeavored to alleviate some of the frustrations as far as admissions are concerned. It also provides for lectures germaine to the "seniors" special interests and also about newer developments of medicine in general.

Further self-help measures will be researched. Social gatherings for the physicians and their wives have been enthusiastically received. All these activities are first steps in the right direction.

Other communities, other hospitals should take notice and emulate.

The doctors in active practice should ponder, for THERE FOR THE GRACE OF GOD GO I!

H.E.M., M.D. (Ret.)
Pompano Beach

* North Ridge General Hospital

WORTH REPEATING

Medical school admissions: winds of change

Different kinds of men and women can practice medicine competently, and so most medical schools look for students whose individual talents differ widely and seek a student body with a diversity of backgrounds and interests.[1] At one time the majority of medical students came from upper-middle-class families, who traditionally emphasize education for their children.[2] However, during the past two decades, most schools have attempted to broaden the socioeconomic mix of entering medical classes and to expand educational opportunities for racial/ethnic groups that are underrepresented in medicine. Thus, current graduates are not only bright and superbly trained but are also representative of a broader spectrum of society.

Unfortunately, current financial constraints may force a change in the composition of entering classes, with consequent change in the type of individual who will enter the practice of medicine after

the completion of training. Medical schools are having difficulty in maintaining competitive faculty salaries and research programs. Loss of federal capitation support, appropriations for state medical schools which have not kept pace with inflation, and sharply rising costs of providing the education have forced most medical schools to a steady increase in tuition.[3,4] This financial "squeeze" has been particularly acute at private schools whose endowments have not kept pace with rising expenses, so that income from tuition must now pay a larger share of the educational costs. Since federal support of low-interest loans has been reduced dramatically and federal dollars for scholarships have been almost eliminated, the student-affairs offices in medical schools have difficulty in helping students plan how to pay for their education.

At first, the sharply increased tuitions and sharply decreased financial aid will affect mainly private medical schools. Eventually, however, the effect will be felt also in state-supported schools.[5] Not used to large debt and frightened by it, candidates from lower- and middle-income families will increasingly come to feel that they cannot afford to attend medical school.

There is already a feeling among some college students that it is too expensive to attend medical school. Furthermore, students are graduating from college with more debts than their predecessors had. Thus, bright and able students who would otherwise plan a career in medicine may not appear as applicants. A recent article quotes a medical student: "Anyone even considering medical school must be scared silly about the incredible debts looming before them."[6]

The financing of medical school expenses can have a critical influence not only on the quality of education but also on the free access of the most talented students to that education. Most schools are dedicated to training the best-qualified applicants without regard to their ability to pay. With escalating costs and sharply rising tuition, this policy may need to be reconsidered, unless the students are able to accept the high indebtedness that will accompany their education. Already on the national level, there seems to be a decline in the applicants from blue collar and rural families. If this trend continues, the nation may end up with a medical profession drawn from families of the highest socioeconomic segments of our society. This also carries the implication that fewer physicians will return to the inner cities and rural areas to practice. Those few graduates who are from middle- and low-income families will have very large monthly debt repayments due after completion of their training. During the approaching decade, it is expected that the debt at graduation from medical school will average $50,000, as compared with $18,000 among house officers who graduated in 1979.[7] This debt comes due at a time when other deferred wants — for housing, furniture, automobile, and so on — also press in. It seems unlikely that the economically disadvantaged person would seek a career whose preparation generates such a huge debt.

The implications of this level of indebtedness for patterns of medical care in the future are unsettling. Cost containment in health care cannot be considered separately from the financial burdens placed on physicians. Only through professional fee revenues can these education debts be repaid. Individual financial pressure will be the most potent force in guiding new physicians away from primary care specialties and underserved areas, both in rural and in urban environments.[8] Unmanageable debt may force young physicians to choose higher-paying careers, prescribe more revenue-producing procedures, or vastly increase their patient loads. Any of these choices may adversely affect health-care delivery.

Families, schools, the private money market, and the government must jointly provide adequate financing. Subsidized loans and grants are needed for economically disadvantaged and lower-middle-income students if the public is to be served in the future by a medical profession that is drawn from all walks of life.

Joseph M. Kiely, M.D.
Chairman, Mayo Medical School Admissions Committee

References

1. Rhoads, P.S.: Premedical Students, Admissions Committees, and 'the Physician as an Educated Person.' JAMA 247:2671-2673, 1982.
2. Baird, L.L.: The Characteristics of Medical Students and their Views of the First Year, J Med Educ 50:1092-1099, 1975.
3. Iglehart, J.K.: Health Policy Report: Shrinking Federal Support Brings New Era to Education in the Health Professions, N Engl J Med 305:1027-1032, 1981.
4. Henikoff, L.M.: Medical School Grads are Bright, Eager, and in Debt, Am Med News, December 25, 1981, p. 6.
5. Fortunato, T.: Concern About the M.D. Price Tag: The Doctor Bill That Puts Doctors in Debt, Hopkins Med News 7:2-9, 1982.
6. Study Finds Med Ed is Still Good Investment, New Physician 31:20, January/February 1982.
7. French, F.D.: The Financial Indebtedness of Medical-School Graduates, N Engl J Med 304:563-565, 1981.
8. Round the World: Debt and the Young Physician, Lancet 1:89, 1978.

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Are we doing enough?

Doctors of Medicine are privileged and gifted persons. I believe that as physicians we have shirked our responsibility by not sharing our privileges and gifts with our fellow people. Besides practicing Medicine and treating the ill, the maimed, and the mentally disturbed, and researching for the cause of illness as well as the treatment for disease, are we doing enough for our fellowman? Many of us would ask, "What else can we do?"

It seems that many avenues are open for the physician to share his privileges and his gifts by giving more of himself to community service. Yes, we have physicians who are bank directors, members of corporate boards, partners in real estate ventures, owners of charter boats and planes, owners of hospitals and ambulance companies, and for the most of the above, physicians are compensated financially, — and I find no fault with that.

But there are too few of us involved with church and archdiocesan boards, synagogue and temple councils, college boards and directorships. Salvation Army, YMCA, United Fund, and other charity fundraising projects, and state and federal political committees involved in the selection of candidates for public office.

Unfortunately now, we are viewed by the general public as entrepreneurs only. Doing our duties for compensation only. There was a time as I was growing up that the physician was viewed as the community leader, the family friend, the humanitarian, the "man of the year," the "man of the decade." Today even amongst our own groups, both hospital staff and county society alike, we physicians lack the courage to name an outstanding man or woman for their good deeds or service rendered for their fellow physicians and/or hospital in the name of public service. Is our mentality such that we consider it snobbish or mundane (whichever way you wish to view it), to recognize and honor a physician who would serve the community in other than medicine-related activities?

I strongly believe that many physicians are qualified to be community service leaders, but are restrained because of peer pressure amongst physicians' social groups who might in fact ridicule them or drop them out of the social circle. We individually and as a group are capable of leadership roles because of our God-given intelligence and ability, and we should develop and utilize this capability in the interest of the community as a whole as well as the profession of medicine. If we believe in our community as the place we want to live and practice Medicine, and have our children develop, grow, and be educated, then we should encourage, admire, and support the members of our profession who not only practice Medicine, but who also have the courage and make the sacrifice to work in community service.

If more physicians were involved in the service of the community, won't you agree that the community would be a better place to live and practice medicine?

Think about it! With little effort, you could be not only the man of the hour for your patients, but the man of the year of your community. And then you would be doing enough.

Ernest G. Sayfie, M.D., F.A.A.F.P.
President, Broward County
Medical Association

Reprinted with persmission from *The Record* of Broward County Medical Association, September 1983.

CORRECTION

Correction in Notes & News

The title on page 37 of the January issue (Vol. 71, No. 1) should have read, "Dr. Coleman reappointed by President Reagan to the Board of Regents at USUHS."

"Further experience in ambulatory EEG monitoring"

In the January issue (Vol. 71, No. 1), page 18, a paragraph read "'Blackout' patients with recorded normal standard EEG and recorded abnormal 24 hour ambulatory EEG data:" should have read "'Blackout' patients with recorded normal standard **EKG** and recorded abnormal 24 hour ambulatory EEG data:"

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BOOK REVIEWS

Book Review Editor — **F. Norman Vickers, M.D.**

About your medicines

By authority of the United States Pharmacopeial Convention, Inc., 396 Pages. Price $4.95 soft cover. USP DI, Publications Dept.

This is a comprehensive reference work compiled by and distributed by the U.S. Pharmacopeial Convention, Inc. This authoritative body is composed of experts in medical therapeutics representing the spectrum of government agencies, professional organizations, and educational institutions.

About Your Medicines is directed to the laity and includes all commonly used prescription and over the counter drugs. It has an easy to use format which includes both the generic and brand names in the index. The drug information is presented under the generic heading but includes all the common brand names. The content includes its availability with or without a prescription, its use, precautions, incompatabilities, and side effects and is presented in an unemotional manner.

I am impressed favorably with this book and believe it presents our patients with usable and needed information. It should help balance drug advertising and create patients who are more compliant in following drug treatment. It will also be a handy addition to the bookshelves of those of us practitioners who are not heavy on drug therapies and may be overwhelmed by all the different names.

James K. Conn, M.D.
Tallahassee

- Dr. Conn is in private practice of general surgery in Tallahassee.

Infanticide and the handicapped newborn

By Dennis J. Horan and Melinda Delahoyde, 127 Pages, Brigham Young University Press, Provo, Utah, 1982.

This brief book touches on many controversial and emotional issues. "Life and Death" decisions, particularly as they concern the handicapped newborn have become a heavy burden to many practicing physicians. The difference between "treatable and untreatable" and between "usual and extraordinary measures" is sometimes difficult to make. In many instances, it depends upon personal experience or practice setting.

Despite my initial reservations because of some religious overtones, I found the book interesting and worthwhile to read. At least it makes you stop and think about how precious and fragile human life is. Also these issues have become of practical importance in light of the recently proposed "Baby Doe Legislation."

Benjamin E. Victorica, M.D.
Gainesville

- Dr. Victorica is Professor of Pediatric Cardiology at the University of Florida School of Medicine.

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Auxiliary Liaison Editor — **Mrs. L. G. (Mae) White**

Aging made better

The Florida Medical Association Auxiliary is making a positive effort to improve the quality of aging in our state. A special emphasis has been placed on aging because it is one of the most critical issues in Florida. Today over 2¼ million Floridians are over age 60. Florida has the fastest growing older population in the United States. One person in six is over 65. By the year 2000, one in four will be over 65. The average life expectancy after retirement is three to nine years, but by moving to Florida, the retiree may add 1½ years to this figure. Aging is more of a concern in Florida than anywhere else in the United States. Floridians must be the trend-setters so that there can be a true "celebration of aging." All eyes are on us.

We must start with ourselves — with our own mind-set. The first step is to throw out those shop-worn stereotypes of the elderly which have permeated our attitudes for years. "Old folks are careless drivers." "Old people are crabby." "Old people do not like kids." "They are set in their ways." These qualities are not peculiar to the elderly, but can be applied to certain segments of any age group. Older persons have unique personalities, and should be considered as individuals.

Auxilians are encouraged to contact senior citizens as soon as possible after their arrival in the community. Retirement can be Paradise or Purgatory. The first three to six months are critical. Newcomers are busy decorating the house, cleaning the yard, and learning the community. They must make outside personal connections or almost certainly, they will suffer from "cultural shock" after an active period. Retirees will miss their jobs, family, former homes, church and friends. They may feel "rootless." For the most part, they cannot go back, so they need help in making social, recreational and educational connections. Auxilians can help senior citizens make these connections.

Auxilians are urged to remember that appreciation for the gifts of the elderly is essential to productive work in the aging. Older people have expertise, wisdom and experience which they are eager to share if given the chance. They are excellent in volunteerism because this satisfies their desire to feel needed. Seniors are dependable, dedicated workers. They are successful as teacher-aids, coaches, hospital volunteers, foster grandparents, church workers and in making phone contacts for other seniors. Activity wards off depression and in some instances it is a true life-saver.

Senior citizens need recreational experiences. Auxiliary members can help them locate clubs, sport facilities and cultural events. Sometimes it is necessary to find means of transportation to these activities for those who are frail or no longer drive themselves.

Auxilians are encouraged to help senior citizens locate educational resources in their community. They exist in churches, YMCAs, senior centers, community colleges and universities. Community Instructional Services is a state-wide program providing non-credit instructional services for persons 55 and older. Education opens doors of opportunity for people of all ages. We are never too old to learn.

Auxilians continue to pursue projects for older persons who are confined to care centers or their homes. Volunteering in nursing homes and hospitals, being pen-pals to patients, visiting them and trying to keep them in touch with the community are on-going activities.

It is the aim of the FMA-A program on aging to take a positive role in promoting the dignity of our burgeoning senior population, keeping them as active as possible for as long as possible. The Auxiliary hopes to have the elderly out of seclusion, off the sidelines, and in the mainstream of life.

Mrs. Fred P. (Ann) Swing
Chairman on Aging, FMA-A

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I've been on this table. Are you next?



Arthur Ashe
National Campaign Chairman
American Heart Association

After I had my heart attack, doctors used this cardiac catheterization procedure to find out why. They found a reduced supply of blood going to the heart muscle itself. So they performed coronary artery bypass surgery to increase the supply. Nearly 40 million other Americans have some form of heart disease, stroke, or related disorder. Many will make it to this table.

The American Heart Association is fighting to reduce early death and disability from heart disease and stroke with research, professional and public education, and community service programs.

But more needs to be done.

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Summary of the FMA Board of Governors Meeting March 9-10, 1984

The following is a summary of the major actions taken by the Board of Governors at its meeting March 9-10, 1984:

THE BOARD:

AMA-PHYSICIAN FEE FREEZE

The Board expressed unanimous support for joining the American Medical Association in requesting that physicians voluntarily freeze their fees for a one year period and that they also continue to take into account the financial circumstances of their patients especially the unemployed, the uninsured and those under Medicare and to accept reduced fees when warranted. The Board supported the freeze with recognition of the difficulty that many physicians in Florida may have in complying because of the professional liability crisis. It was also recognized that payment for physicians' services is not the major cause of health care inflation but that the medical community should take a leadership role in efforts to control the increase in health care costs and that voluntary action is the most effective means of accomplishing this goal.

ALTERNATE HEALTH CARE DELIVERY SYSTEMS

The Board authorized the dissemination of a patient informational brochure to county medical societies which outlines questions that patients should ask and have answered when considering participation in alternate health care delivery mechanisms such as HMOs, PPOs, IPAs and others. The Board further directed that a central informational source regarding alternate health care mechanisms be established at the earliest possible date at the FMA Headquarters and that the FMA membership be kept informed regarding developments and activities relating to these health care delivery mechanisms through existing FMA publications.

PROFESSIONAL LIABILITY

Constitutional Initiative

The Board determined that the constitutional initiative for tort reform approved by the House of Delegates will be submitted as one amendment encompassing summary judgments, limitation on non-economic damages and the elimination of joint and several liability.

Legislative Activity

The Board further directed that bills encompassing the same proposals as those included in the constitutional amendment be prepared for introduction for consideration in the 1984 Legislative Session at the earliest possible date.

FMA-SPONSORED INSURANCE PROGRAMS

The Board approved Loyalty Life Insurance Company and Old Line Insurance Company for the FMA-sponsored life insurance program and authorized PIMCO to enter into a general agent's agreement with both of these companies.

COUNCIL AND COMMITTEE REPORTS

COUNCIL ON MEDICAL ECONOMICS

Workers' Compensation

Physician Services

Approved the following actions to be taken if the Workers' Compensation Three-Member Panel reduces the physician fee schedule to the 50th percentile of the Division of Workers' Compensation Data Base:

1. Request a hearing under the Administrative Hearing Act once the Workers' Compensation Physicians' Fee Schedule is promulgated as a rule.

2. Authorize the presentation of testimony at the hearing challenging (1) the validity of the data base used by the Three-Member Panel, and (2) the use of the 50th percentile for establishing the 1984 fee schedule.

3. If the results of the hearing are unacceptable, file suit against the Division of Workers' Compensation, if legally reasonable.

Medical Director

The Board reaffirmed the Association's continued efforts to seek the appointment of a physician as medical director to the Division of Workers' Compensation.

Cost of Practicing Medicine Survey

Approved conducting a survey to determine the cost of practicing medicine in various regions in the state of Florida to assist in the implementation of Substitute Resolution 83-7 adopted by the FMA House of Delegates at its meeting in May 1983. This Resolution resolved:

That the FMA continue its efforts to obtain equitable fee differentials throughout the state and that the fees sought be equivalent to the usual and customary fees charged in the various communities; and be it further

That if FMA is unsuccessful in achieving fee differentials under its present course of action, the FMA seriously study the possibility of litigation which would eliminate the present Workers' Compensation Medical Fee Schedule and instead provide reimbursement based upon usual and customary charges for such services as is done in 33 states; and be it further

That FMA support the concept of regional differentials Workers' Compensation fee schedules for physicians practicing medicine in counties where the cost of living is higher than the average for the state of Florida.

DRG Educational Seminars

Authorized the FMA to participate in the prospective pricing system (DRGs) seminars being sponsored by the American Association of Retired Persons, Blue Cross and Blue Shield of Florida, the Florida Hospital Association, the Florida Council on Aging, and the State Insurance Commissioner's Office.

Meeting with Florida Business Leaders

Authorized the President and other appropriate FMA representatives to meet with prominent business leaders in Florida to establish an ongoing relationship for addressing health care issues of mutual interest.

PRO

Reaffirmed the actions of the House of Delegates at its meeting in May 1983 directing that the FMA, through the Florida Medical Foundation or other appropriate entity, apply for designation as the statewide professional review organization (PRO) in Florida and directed that this be carried out through a single state organizational structure with branch offices established in appropriate areas throughout Florida in cooperation and coordination with local county medical societies.

COUNCIL ON MEDICAL SERVICES

EDBs

Expressed commendations to the Secretary of the Department of HRS and the state health officer for their efforts in publicizing the problem of EDB residue in food and water, and for developing the policy that the health of the public must be protected by limiting exposure to this toxic chemical until further research establishing safe and acceptable levels in food and water is established.

The Board also commended the Commissioner of Agriculture for his firm position on EDB under extremely difficult circumstances and for his complete cooperation with the Department of HRS in accepting recommendations that were submitted.

Pre-Participation Physicals

Recommended to the Florida High School Activities Association that pre-participation physicals be required once at the entry of junior high school level and once at the entry of high school level with annual updated histories on a yearly basis.

High School Activities Form

Endorsed the High School Activities Form with urinalysis and hematocrit testing being optional.

Health Education Curricula

Encouraged the Department of Education to incorporate health and fitness courses into the curricula for middle grades five through eight preferably through health and physical educational courses.

Synthetic Heroin

Approved distribution of the FMA membership with synthetic heroin memorandum developed by the State of California Department of Alcohol and Drug Programs. This memorandum describes the types of synthetic heroin that are in existence and reactions of its consumption.

Public Education Programs

Senior Citizens

The Board reaffirmed the development of public education programs on support services that are available to citizens including promotion of the concept of family health care and that a pilot project be initiated for an educational campaign outlining home health care and other services available to the elderly.

Emergency Medical Services

Approved the establishment of a public education program for the Legislature, the public and the FMA membership regarding emergency medical services with emphasis on the Florida Medical Foundation/ Emergency Medical Project and Trauma.

COUNCIL ON SCIENTIFIC ACTIVITIES

Foreign Medical Graduates

Approved the concept of the need for improved quality control over licensure of foreign medical graduates and their ability to sit for licensure examination in Florida and recommended to the State Board of Medical Examiners that it allow to sit for licensure examination only those graduates of medical schools which have demonstrated they meet the minimum accreditation standards as defined by the Liaison Committee on Medical Education and have completed clinical clerkships and/or residencies in institutions affiliated with LCME accredited medical schools or accredited by the Accreditation Council on Graduate Medical Education (ACGME).

Continuing Medical Education

Reaffirmed the philosophy of mandatory continuing medical education established by the FMA House of Delegates in May 1972 and directed that a letter be sent to all FMA members who have not verified the CME requirements in their most recent reporting cycle and that each member be advised as to the requirements of the program.

JUDICIAL COUNCIL

New County Medical Society Charters

Approved a recommendation to the House of Delegates that a charter from the Florida Medical Association be issued to the proposed Bradford County Medical Society.

Recommended to the House of Delegates that a charter from the Florida Medical Association not be issued to the proposed St. Johns County Medical Society.

COMMITTEE ON IMPAIRED PHYSICIANS

American Medical Society on Alcoholism

Approved the recommendation that the American Medical Society on Alcoholism be invited to join the Committee on Impaired Physicians as a co-sponsor for the Section on Chemical Dependency at the 1984 FMA Annual Meeting.

Impaired Physicians Program Funding

Authorized the Impaired Physicians Committee to request that other in-state professional groups using the FMA Impaired Physicians Program contribute $10 per dues paying member per year toward administration of the Program.

COUNCIL ON LEGISLATION

Adopted the following positions with regard to legislation to be considered during the 1984 Legislative Session. This is in addition to legislative positions previously adopted by the Board of Governors.

Opposition to legislation calling for:

- Hospital staff privileges for nurse anesthetists (HB 620/SB 384); psychologists and lay midwives (HB 418/SB 277); nurse practitioners (HB 565/SB 277) and certification of medical assistants (SB 97).
- Legislation mandating the summary of treatment alternatives for breast cancer (HB 279/SB 157).
- Legislation requiring that all health insurers provide a "finder's fee" to individuals who discover an overage in their health insurance policies (HB 179).

Disapproved of legislation:

- Requiring the directed donation of blood by a donor to a patient who is a relative (HB 241).
- Reducing the amount of time a medical faculty certificate in lieu of a Florida license to practice medicine is in effect.

Endorsed legislation:

- Expanding coverage for newborn children in health insurance policies to include the newborn child of a family member of the insured or subscriber (HB 260).
- Removes the prohibition against individuals affiliated with a medical school from serving on the State Board of Medical Examiners.
- Authorizes the licensure of osteopathic physicians by the Florida Board of Osteopathic Medical Examiners.

Corneal Transplants

Expressed support for the Florida Society of Ophthalmology in opposing an effort to require written authorization from the next of kin of a decedent in corneal transplant cases.

COUNCIL ON SPECIALTY MEDICINE

Specialty Group Recognition

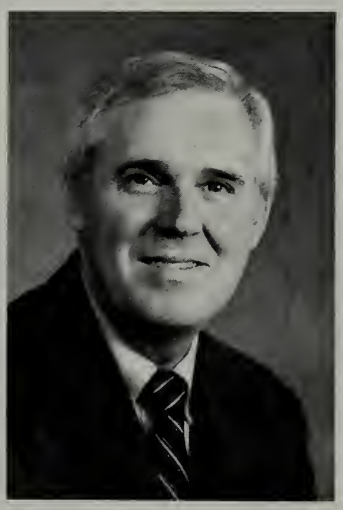
Approved continuing recognition for the Florida State Surgical Division, International College of Surgeons.

Blue Cross and Blue Shield PARS Plus Program

The Board received a report on the PARS Plus Program sponsored by Blue Cross and Blue Shield of Florida and directed that a careful study of the components of the Program be conducted in order that an appropriate FMA position can be developed as warranted.

PRESIDENT'S PAGE

Hold the line



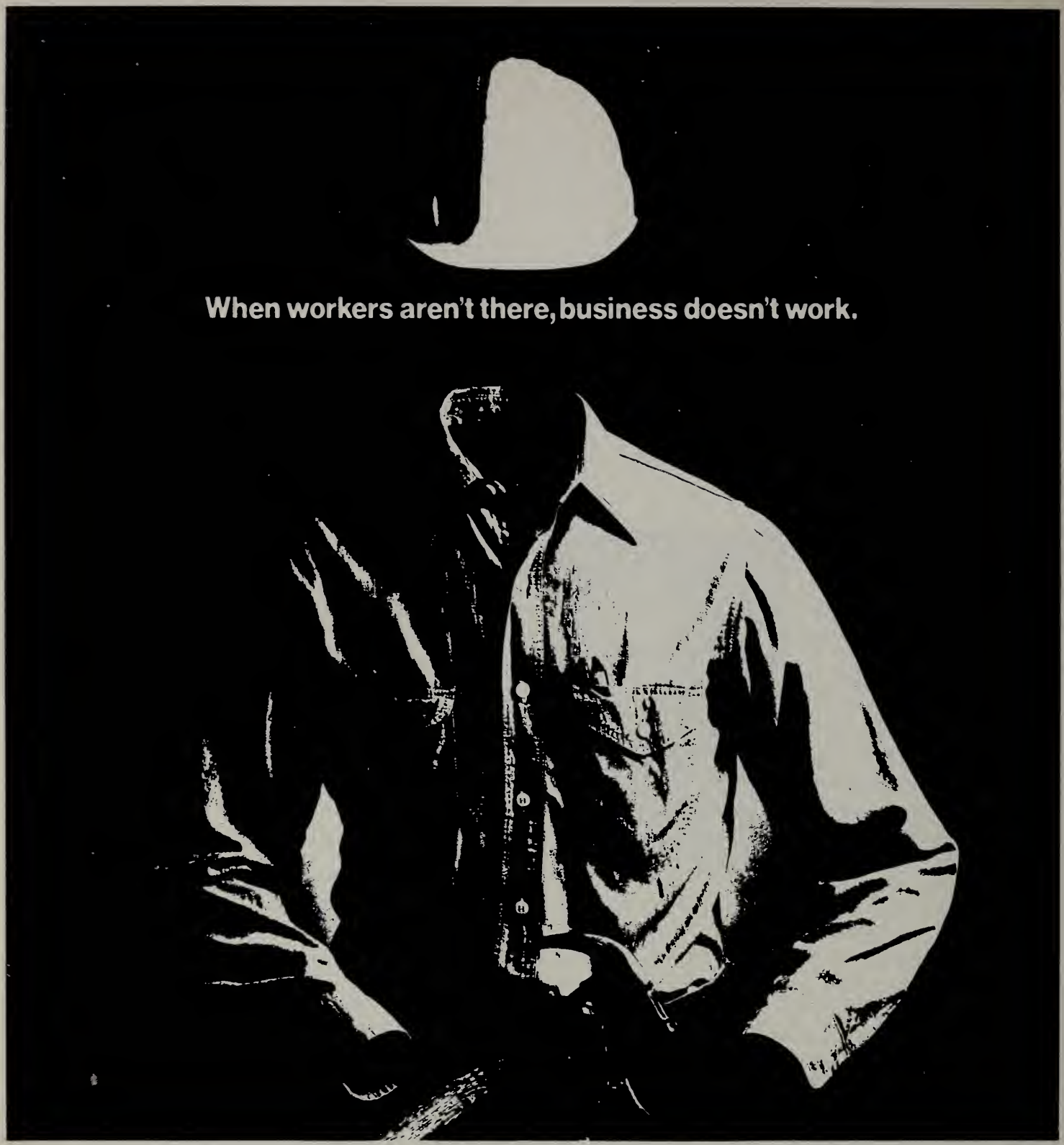
The activities of organized medicine have escalated to unbelievable and almost unmanageable proportions. Legislative hearings are proceeding with speed and tenacious assault on medicine in preparation for the legislative session. Lay midwifery, licensing of radiology technicians in doctors' offices, hospital privileges for psychologists, nurse practitioners, nurse midwives, nurse anesthetists, and pharmacist health care consultants (pharmacists who desire legislation to permit diagnosis and treatment of disease by pharmacists for which they may charge a fee), hospital rate regulation and medical malpractice are only a few of the complex issues requiring our attention in the legislature.

In our respective practice areas, we are battling with the flood of alternative health care initiatives and the voluminous advertisements enticing patients to subscribe to the various gimmicks for health services. And sadly, too many physicians, fearful the competitive initiatives will reduce their practice volume, are signing up to participate in these health care alternatives. And so, we naively promise to give 20% more care for 20% less. The fee for service and the doctor-patient relationships are being substituted by contracts with corporations and companies which have made health care a business. In doing so, we have transferred the decisions in health care from the physician and the patient to a central or administrative authority, not in the name of quality of health care but to control cost.

The cost of health care is a national issue and poorly understood. The cost of Medicare has continued to increase, not because of wholesale greed, but because the people for whom the Medicare system was designed are living five to seven years longer than expected when the system was originally designed to serve the sixty-five to seventy year olds. Medicare today is paying 30% of claims for people in their last six months of life. Medicine needs to develop a system to care for the chronically ill in their homes with loved ones, or in less expensive facilities than acute care hospitals. It is not proper use of resources to pay for sickness without investment in educational programs in wellness and disease prevention. Employers cannot support total health care coverage for employees without some co-participation with the consumer which will discourage over utilization in the form of co-insurance or a base deductible requirement. Why should patients require admission to expensive acute care facilities for evaluation or treatment which can be performed as an outpatient or in an ambulatory care setting? Society must find a way to care for the sick who are indigent without passing on the costs to only those who use the facilities.

During this period of great turbulence and evaluation of the present health care delivery system, let each of us, to the best of our ability, do our part in keeping our fees as moderate as possible to demonstrate to our patients and the public that we do care and thus form a partnership for the future. Let us educate ourselves and the public — together.

J Lee Tackeryes



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EDITORIAL

Pre-term birth prevention

In the months of September, October and November 1983, one of the largest and most intensive public health professional education programs ever mounted was presented throughout the State of Florida. Pre-term Birth Prevention Seminars, using the March of Dimes/Creasy Protocol, were presented in the eleven HRS Districts throughout the State to more than 1500 health professionals — doctors, nurses, nurse midwives, nutritionists, social workers, etc. The response from the evaluations of the seminars was highly enthusiastic, especially for the prevention concept presented in the program. The Public Health Units throughout the State are expected to have the program in operation after December 1, 1983 and will be monitored closely on their implementation of the program and of course, the results.

The model program for this protocol was able to effect a drop in the number of low birth weight babies from 7% to 3.5% in the San Francisco area after one year of implementation. A similar program in France dropped the percent of low birth weight babies from 10% to 3% in the course of two or three years. Our goal in Florida is to cut the number of low birth weight babies (10,500 in 1982) by half in the next five years.

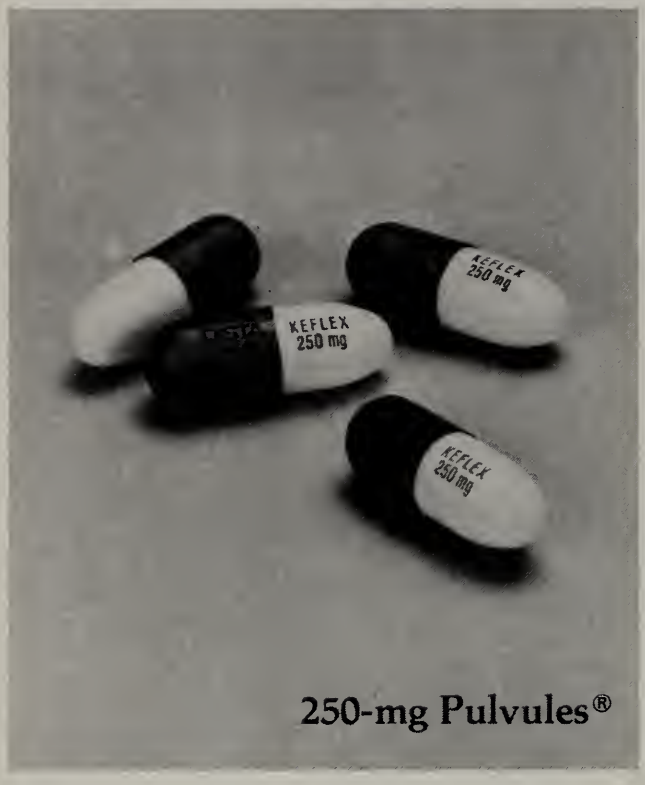
This will not be an easy task since Florida is still growing rapidly, and growth is what is swelling the numbers of low birth weight babies so that many of our excellent neonatal intensive care units have become seriously overcrowded. To reduce the numbers, we will need the enthusiastic cooperation of all members of the FMA. The program has had the strong endorsement of all the major health care providers and hospital groups throughout the State, and members of the Association were notified of the program through my article on prevention of low birth weight in the special Perinatology Issue of *The Journal* in September 1983. However, publishing an article in a journal does not mean that everybody will get the word, so we are sending a copy of the protocol and the original Creasy article out to all members of the Florida OB/GYN Society — who will be on the receiving end if patients need to be referred into the hospital for tocolytic drugs. Continued all-out support of programs such as this one gives medicine a chance to show its very best side, while at the same time, combating the most disastrous perinatal problem that we have. Protocols such as this for the prevention of pre-term birth are rapidly becoming the standard of care across the United States. Florida is the first to adopt and implement such a program statewide and all physicians are urged to become familiar with this program and start using it in their own practices if they are caring for pregnant women.

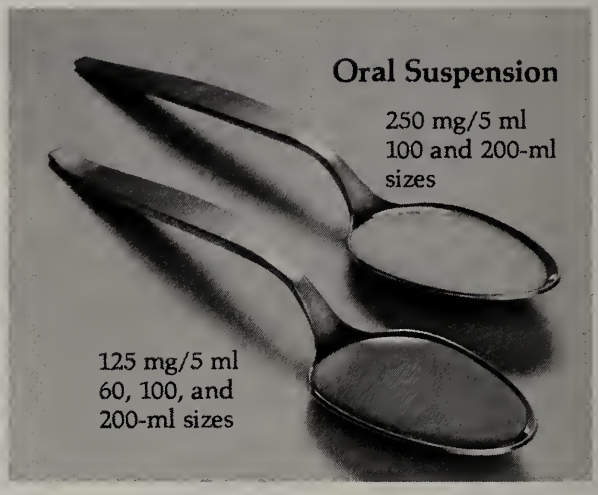
Reducing the number of low birth weight babies in Florida by half in five years is not going to be an easy task. However, if all people providing health care for women in Florida become familiar with the program and cooperate in its implementation, we can do it. So far the response and cooperation from both public health units and private practitioners has been fantastic.

Charles S. Mahan, M.D.
Medical Director, Maternal and Child Health
Professor of OB/GYN
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Ethylene DiBromide (EDB)

A diagnostic and therapeutic problem for the practitioner

Nicholas G. Alexiou, M.D.

ABSTRACT: Ethylene DiBromide (EDB) is a toxic chemical introduced into the environment for commercial reasons but now has entered the food chain, has contaminated water sources and threatens the health of exposed workers and consumers. It poses a diagnostic and therapeutic problem for physicians.

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Ethylene DiBromide is one of many new toxic chemicals that has found their way into the human body, and likely will provide diagnostic and therapeutic frustrations for practicing physicians. Where does one begin? Where does one find information? How can the physician ameliorate the problems of occupational and environmental toxic exposures?

What is Ethylene DiBromide (EDB) • EDB is a reactive molecule formed by treating natural bromide-containing brines with chlorine to replace the bromine with chlorine, releasing elemental bromine. Gaseous ethylene then is introduced and reacts with liquid bromine to form ethylene dibromide. The chemical formula is CH_2BrCH_2Br with a weight of 187.88. The melting point is 9.6°C while the boiling point is 131.4°C. It is nonflammable and is soluble in ethanol, ethyl ether and water. It is a clear, colorless, heavy liquid with a distinctive odor usually described as mildly sweet.

It is an additive in leaded gasoline used to prevent lead oxides, formed from the burning of tetraethyl lead, from building up in the cylinders of automobile engines. It is used as a fumigant for flour milling equipment and for citrus, papayas, pineapples, and mangos. It is also an intermediate in the synthesis of dyes and pharmaceuticals; a solvent for resins, gums, and waxes; and a fire retardant.

EDB is considered an alkylating agent capable of introducing cross-links into biologic material and thus can affect normal DNA separation and subsequent cell division. It is also capable of altering the chemical behavior and physical characteristics of cellular constituents so as to cause changes in the normal physiologic processes of biologic systems.

The greatest use of the manufactured EDB (85%) is as an antiknock additive in leaded gasolines. It has been in use for this purpose since 1921. The remaining 15% of EDB produced is used as fumigants, insecticides, nematocides, or as synthetic intermediates in industrial processes.

The four producers of EDB are PPG Industries, Ethyl Corporation, Great Lakes Chemicals Corporation, and Dow Chemical Corporation.

Human toxic effects arise from skin absorption, inhalation of the vapor, accidental ingestion, and eye absorption.

Skin reactions include local hyperemia, followed by intense pain, blistering and ulceration. Repeated exposures can lead to skin sensitization reactions.

Inhalation reactions include pharyngeal and bronchial irritation, labored breathing and acute respiratory tract injury. Inhalation exposures are accompanied by conjunctivitis, anorexia, headaches, central nervous system depression, and psychological depression. Chest and abdominal pain, restlessness and nervousness have been reported.

Ingestion exposure is usually accidental and may result in death. One woman accidently ingested 140 mg/kg became nauseated and began to vomit. She became agitated, had abdominal pain, developed tachypnea, a weak sporadic pulse and died. Autopsy revealed lung edema and congestion, reddening of the intestinal mucosa, massive centrilobular liver necrosis and renal tubular epithelial damage.

Eye exposure results in conjunctivitis, corneal opacities, purulent conjunctivitis and ulcers of the eye.

Experimentally exposed animals have shown parenchymal degeneration of the spleen and muscle degeneration of the heart. CNS effects have been noted with symptoms of agitation, restlessness, body tremors, and loss of consciousness. Damage to the adrenal glands and testicular tissue has also been noted.

The biologic half-life of EDB in animals tested is about 1 day. EDB is rapidly absorbed, metabolized by liver mixed function oxidase systems and excreted in the feces and/or urine regardless of the route of exposure.

Carcinogenicity, metagenicity, and fematogenicity have been reported in animal studies, vertebrate cell cultures, insects, bacteria, plants, and fungi. EDB by itself has toxic properties and serves as a synergistic agent with other carcinogens. The carcinogenicity studies have not been validated by human experience but the potential to induce mutations in human populations is present.

EDB has attracted notice in news reports as a toxic substance that has found its way into the food and water supplies. It is a contaminant of the atmosphere in production areas, where fumigation is taking place, and as a pollutant where leaded gas is used as a motorfuel. Several years ago a controversy flared up concerning its use as a pesticide to control the Mediterranean fruit fly infestation in California. Its continued use poses a significant health hazard for acute and chronically exposed persons.

The OSHA recommended safe limit for EDB vapor inhalation is O.10 ppm. Lifetime consumption of water contaminated by 1 ppb is associated with an increased cancer risk of 2×10^{-3} (two excess cancers per 1000 exposed persons). EPA estimates that a typical applicator of EDB for soil fumigant use, experiences an additional risk of 4×10^{-3} to 4×10^{-2} (four excess cancers per 1000 and 100 exposed persons). This is not taking into consideration the dose acquired by eating contaminated food or drinking contaminated well water.[1]

The dietary risks from EDB contaminated products for a lifetime of exposure have been estimated by the EPA as follows:[1]

for treated grains — 1×10^{-4} excess cancer deaths
for treated citrus — 2×10^{-5} excess cancer deaths
for tropical fruit — 7×10^{-6} excess cancer deaths
for ground water contamination at 1 ppb — 2×10^{-3} excess cancer deaths

Physicians must be aware of the common clinical settings where toxic exposure to EDB is likely to occur.

A typical scenario may include a report that well water has recently been tested by state authorities with identification of low levels of Ethylene DiBromide in the samples. Exposed individuals must be advised to find an alternate source of drinking water.

Another scenario might be a stevedore who just realized from news reports that the fruit he has been loading for shipment to Japan has been fumigated with EDB and worries that this will affect his reproductive capacity.

A third case might be a service station operator who has learned that the gasoline he pumps everyday contains EDB and worries that it is the cause of his depression.

Each of these exposures is most likely to be minimal. However, most physicians lack familiarity or knowledge of the sources of exposure and the likely toxic effects in the acute and chronic phases of EDB exposure. This is a new area of toxicology.

What can one do • One can begin the evaluation with a detailed exposure history. The goal is to get an estimate of the dose level of the exposure. How long, what volume, what concentration, what was the quality of the exposure as well as who else was similarly exposed should be recorded. This inquiry is followed by an extensive review of systems directed

at potentially affected organ systems such as skin, heart, lungs, liver, kidneys, and nervous system. The physician should look for new symptoms or aggravation of existing symptoms. The review should also look into the reproductive history and pregnancy wastage since EDB has been classified as carcinogenic, mutagenic and terratogenic.

The studies to date show toxicity on the organ systems from relatively high levels of exposure. Low levels have not shown evidence of toxicity and the physical examination may not reveal any physical abnormality. The laboratory tests of exposed persons may also not reveal any abnormality at low levels of exposure. Specific tests for absorbed dose of EDB such as a bromide level are not routinely performed in most clinical laboratories and will require experience for interpretation. Increased bromide ions may be found in the blood after exposure but is of limited value in biologic monitoring because of the low concentrations present at acceptable levels of exposure. False positive tests can be associated with use of bromine-containing over-the-counter medications. Blood bromine concentrations ranged from 1 mg/100 ml to 17 mg/ml in a group of EDB production workers operating stills.[2]

What is the next step • The establishment of normal values for the usual screening tests used to ascertain heart, liver, lung, and kidney function is important. First to document them, and second, to relieve the patient that there is no evidence of damage to the organ systems up to this point. This also allows the physician to establish a baseline for follow-up evaluation studies which are essential over the next few months if symptoms arise.

For workers regularly exposed to EDB, the federal regulatory agency, OSHA, has ruled that employers must conduct environmental monitoring and that health effects of exposure, if any, be determined in a surveillance program. The proposed medical surveillance includes a detailed work and medical history, complete physical examination including pertinent laboratory evaluation and assessment of pulmonary function when a respirator is required on the job. Chest x-rays are recommended initially and every five years. The laboratory tests include protein, albumin, alkaline phosphatase, LDH, SGOT, SGPT, GGTP, cholesterol, calcium, phosphorus, BUN, uric acid, anc creatinine. Kidney function is monitored by urinalysis. This protocol should serve to record patient exposures for monitoring purposes by the private physician. It is likely that employees could obtain copies of information, at the employers' expense, for the physician's records. For non-work-related exposure, testing would have to be obtained at the patient's expense.

The physician should recommend avoidance of smoking and alcohol to simplify the establishment of a diagnosis of toxicity from exposure to EDB. Individuals taking disulfiram (Antabuse) also should discontinue its use since it potentiates the carcinogenic effects of EDB. The physician can recommend a good diet, rest, and exercise as supplements for health support.

Finally, one should seek the patient's cooperation to keep the physician informed of trials of self-medication and to avoid therapies of unproven value such as the taking of high potency vitamins. The contractual agreement of doctor and patient should be reinforced. The physician should show concern and insure that all available information will be acquired on the subject for follow-up purposes and that a referral to an expert for consultation may be made.

Where are the experts and where can information on EDB be found • The experts are pharmacologists and toxicologists generally associated with medical centers or state and federal agencies. They are responsible for monitoring and approving the use of chemicals such as EDB. In the case of EDB a reference for current information on what is known is the Federal Register.[3] Additional references include the NIOSH publication on the criterion for a recommended occupational exposure standard. Originally published in 1977,[4] it was revised in 1981.[5]

Other sources of information include poison control centers, state health departments, departments of labor, departments of environmental regulation, and, on the federal level, the offices of OSHA, NIOSH, and EPA. A not widely used but very important source of information is that usually available from the employer and the company medical director. Manufacturers and distributors are required to provide information for all users in Material Safety Data Sheets (MSDS). This is an immediate reliable source of information on the toxic effects of hazardous chemicals or substances found in the marketplace.

A great deal is known about EDB and new investigations are underway to determine other deleterious effects of EDB on humans. The physician, however, has no way at present to help rid the body of the unwanted chemical. He cannot falicitate its excretion in the feces or urine. There is no known method to remove the chemical from the water supply or foodstuff consumed each day.

Those exposed to EDB in the workplace have a measure of protection available through OSHA regulations which spell out environmental monitoring requirements, administrative controls, personnel protection equipment, medical surveillance, training and education programs for workers.

Those contaminated through the environment, accidents, or polluted water supplies have no protective support system except that provided by their private physician. The physician can help by supporting concerned citizen groups, patients, and their families and, through his efforts, try to prevent further unnecessary exposures. In a real sense, we are indebted to the news media for awakening physicians to the workplace and environmental hazards from contamination by EDB.

References

1. Federal Register, Volume 48, No. 197, Tuesday, October 11, 1983, Notices.
2. Ott, M.G.; Schwanweber, H.C., and Laugner, R.R.:Mortality Experience of 161 Employees Exposed to Ethylene DiBromide in Two Production Units, Brit. J. Industrial Med. 37:163-168, 1980.
3. Federal Register, Volume 48, No. 196, Friday, October 7, 1983, Proposed Rules.
4. Ethylene DiBromide — NIOSH Criterion for a Recommended Standard Occupational Exposure. DHEW NIOSH publication number 77-221, August 1977, USDHEW PHS CDC NIOSH.
5. Current Intelligence Bulletin 37, Ethylene DiBromide (Revised), publication number 82-105, October 26, 1981, USDHHS PHS CDC NIOSH.

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The role of colonoscopic evaluation following partial colon resection for adenocarcinoma

Patrick G. Brady, M.D.; Barry A. Frank, M.D., and Leonard E. Zeabart, M.D.

ABSTRACT: Patients with a prior history of colorectal carcinoma have a high risk of developing subsequent colonic neoplasms. Sixty-two asymptomatic patients who had prior colon resections for carcinoma were evaluated with colonoscopy, barium enema, stool Hemoccult® determinations, and CEA levels. Forty-six neoplastic lesions including six carcinomas were found. Coloscopy was the most sensitive and specific method of detecting neoplastic polyps and localized carcinoma. Air contrast barium enema and stool Hemoccult® determinations were useful complementary procedures. Total colonoscopy is an essential part of the follow-up evaluation after partial colectomy for colorectal carcinoma.

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Individuals who have had a previous colon or rectal carcinoma have a high risk of developing additional colonic neoplasms. The incidence of synchronous and metachronous colon carcinomas in this group is reported to be 5.5%,[1] however, this may be an underestimation since this study was conducted before the widespread use of colonoscopy. The incidence of local recurrence at the anastomosis may be as high as 10%.[2] The postoperative surveillance of patients who have had potentially curative resections of colorectal carcinomas usually consists of an annual barium enema, and a semiannual proctosigmoidoscopy, CEA determination and fecal occult blood testing. Colonoscopy is rarely utilized as a routine screening procedure to evaluate these patients. Since colonoscopy is a sensitive method of detecting both benign and malignant colonic neoplasms, we have incorporated it into our standard surveillance protocol for the postoperative evaluation of patients with colorectal carcinoma. This report presents our initial findings.

Methods • Sixty-two asymptomatic patients, seen at the James A. Haley Veterans Administration Hospital, who had a potentially curative partial colectomy for colorectal carcinoma have been studied. The surveillance protocol included six stool occult blood determinations and CEA levels semiannually; and barium enema and colonoscopy six months following surgery and annually thereafter. The Hemoccult® slide test was used to determine the presence of occult blood in the stool. The neoplastic lesions found were classified histologically as either adenomas or invasive carcinomas. The adenomas were further characterized as either villous, tubular or intermediate. The invasive carcinomas were staged using

the Dukes classification. The data reported reflect the results of the initial examinations and twelve months of follow-up.

Results • A total of 46 colonic neoplasms were found in 25 of the 62 patients. These included 34 tubular adenomas, four villous adenomas, two adenomas of intermediate type, and six carcinomas. Forty-five of these neoplasms including all six carcinomas were detected with colonoscopy. The size of these lesions is shown in Table 1. Only 13 lesions were within reach of a standard 25 cm sigmoidoscope. Thirty-two lesions were within 60 cm of the anus or colostomy and therefore were theorectically within the reach of a 60 cm flexible sigmoidoscope. Four out of the six carcinomas were beyond 60 cm, three in the transverse colon, and one in the cecum (Table 2). A number of incidental findings were present on colonoscopy and included 18 hyperplastic polyps, varices at the anastomosis in one patient, a suture granuloma at the anastomosis in one patient and a benign stricture at the anastomosis with proximal colitis in one patient.

Air contrast barium enema was performed in 32 patients and single contrast barium enema in 30 patients. Twelve neoplastic lesions were detected with barium enema, however, two Dukes' A carcinomas were not detected with this technique. Of the four adenomas larger than 2 cm in diameter, only two were detected with barium enema. Minute adenomas (◄5 mm) were rarely seen even with air contrast barium enema despite the fact that they were common findings on colonoscopy in this group of patients. Only one tubular adenoma was found on air contrast barium enema that was not detected by colonoscopy.

Hemoccult® determinations were positive with twelve lesions including six tubular adenomas, one villous adenoma, one intermediate adenoma, and four carcinomas. Stool hemoccult determinations were repeatedly negative in two patients with Dukes' A carcinoma. They were also negative in 22 out of 27 tubular adenomas 1 cm or less in diameter.

CEA levels were elevated (► 5 ng/ml) in six patients. These included two patients with carcinoma, one patient with a villous adenoma, one patient subsequently shown to have metastatic disease and two patients in whom no definite cause for the elevation could be identified. The two carcinomas were Dukes' C and were identified with air contrast barium enema, colonoscopy, and stool hemoccult determinations. Importantly, all four patients with localized carcinoma had normal CEA determinations. Findings in the six patients with carcinoma are summarized in Table 3.

Table 1. — Size of Forty-six Neoplastic Lesions

	Adenomas			
Size (CM)	Tubular	Intermediate	Villous	Carcinomas
◄0.5	14			
0.6-1.0	14			
1.1-2.0	6	1	1	3*
►2.0		1	3	3**

* Polypoid
** Two malignant strictures, one malignant ulcer in a mass

Table 2. — Distance From the Anus or Stoma

	Adenomas			
Distance (CM)	Tubular	Intermediate	Villous	Carcinoma
◄25	8	2	2	1
25-60	17		1	1
►60	9		1	4

Table 3. — Findings In Six Patients With Carcinoma.

Patient	Type	Colonoscopic Findings	Barium Enema	Dukes' Stage	Hemoccult	CEA (ng/ml)
1	Synchronous	2 cm Polyp	Normal	A	Positive	2.0
2	Recurrence at Anastomosis	1 cm Sessile, Polypoid Lesion at Anastomosis	Normal	A	Negative	2.2
3	Recurrence at Anastomosis	Ulcerated, Malignant Stricture at Anastomosis	Narrowing at Anastomosis	B	Positive	1.4
4	Metachronous	Ulcerated Mass	Mass	C	Positive	11.0
5	Metachronous	Ulcerated, Malignant Stricture	Malignant Stricture	C	Positive	41.0
6	Metachronous	2 cm Polyp	2 cm Polyp	A	Negative	1.9

Discussion • These results confirm the fact that patients who have had a previous colon cancer are at high risk of developing additional colonic neoplasms. Forty percent of the patients examined had a neoplastic lesion, and 10% had invasive carcinoma. This incidence is higher than that reported in previous studies in which colonoscopy was not routinely performed.[1-3] However, surveillance programs employing colonoscopy have yielded similar results.[4-6] Generally, only 41% of all colorectal carcinomas are in a localized stage when first detected.[7] In this study, 67% of the carcinomas were localized reflecting the value of an intensive screening program in an asymptomatic but high risk group.

Colonscopy was the most sensitive method of detecting colorectal carcinoma in this group of patients. Two localized carcinomas were missed with barium enema and Hemoccult® determinations. Only one carcinoma had both a normal barium enema and a negative fecal occult blood indicating the usefulness of employing multiple screening tests. In two instances, the barium enema revealed a nonspecific abnormality which on subsequent colonoscopy was shown to be a carcinoma. All six carcinomas were detected with colonoscopy and confirmed histologically with colonoscopic biopsy or polypectomy specimens. Others have found colonoscopy to be more sensitive and specific than barium enema in detecting colonic malignancy.[8,9]

Fecal occult blood determinations are a useful screening test, however, not all colonic carcinomas will bleed, particularly smaller non-ulcerated lesions, as indicated by our experience. Occult blood in the stool or a positive barium enema are useful to the colonoscopist by both raising his level of suspicion for a malignant lesion and/or directing his attention to a particular area. Therefore, although occult blood testing and barium enema alone are not sufficient to screen this group of patients, they are useful complementary procedures which provide information at a relative low cost and risk.

Fifty-nine precent of the neoplastic lesions found in this study were tubular adenomas 1 cm or less in diameter. The majority of these lesions were detected only with colonoscopy. Although these small adenomas have a low malignant potential, they are capable of growth and malignant change.[10] It has been demonstrated that removal of rectal and sigmoid polyps reduces the subsequent incidence of carcinoma in these areas.[11] Therefore, detection and removal of small adenomas in a group at high risk for the development of colon carcinoma is a valuable aspect of a cancer prevention program.

Sigmoidoscopy has been part of the standard evaluation of patients with a previous colorectal carcinoma. Recent evidence suggests that the percentage of rectal carcinomas is decreasing while the percentage of proximal colon carcinomas is increasing.[12,13] This may partially account for the fact that only 28% of the neoplastic lesions found in this study were within the reach of a 25 cm sigmoidoscope. Although sigmoidoscopy remains a valuable screening procedure in the general population, screening for occult blood, and colonoscopy in high risk patients are becoming increasingly important.

CEA levels were of no value as a screening test for localized carcinoma or neoplastic polyps. These results are in agreement with other studies showing that CEA is not useful in the early detection of colon carcinoma.[14,15] CEA levels may have limited usefulness as a prognostic indicator or in monitoring the effects of chemotherapy and radiotherapy.

This study indicates that colonscopy is the most effective method of detecting neoplastic polyps and localized carcinoma in patients who have had a prior colorectal carcinoma. Air contrast barium enema and stool hemoccult determinations are useful complementary procedures but are not a substitute for colonoscopy. On the basis of our knowledge of the growth rates of colonic neoplasms, it is recommended that a comprehensive surveillance program in this group include colonoscopy at six months, one and two years following surgery to detect synchronous lesions and recurrence at the anastomosis; and subsequently at three year intervals to detect metachronous neoplasms. Patients with prior colorectal carcinoma are an easily identifiable group at high risk for the development of subsequent colorectal carcinoma in which a properly designed screening program can be productive.

(References available upon request)

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CT biopsy of cerebral toxoplasmosis in AIDS

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ABSTRACT: There is increasing community concern regarding Acquired Immune Deficiency Syndrome (AIDS) which is receiving much media attention. These immunocompromised patients present with a new spectrum of CNS infections. Described is a case report of a Black Haitian with AIDS and miliary tuberculosis. Cerebral toxoplasmosis was also diagnosed by CT guided percutaneous brain biopsy.

Key words: Acquired Immune Deficiency Syndrome, toxoplasmosis, toxoplasma encephalitis, and CT guided brain biopsy.

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Acquired Immune Deficiency Syndrome (AIDS) has recently become a household word associated with significant community concern. These immunosuppressed patients present a new spectrum of central nervous system infections. Prompt diagnosis to provide appropriate therapy is desired. Described is a case of cerebral toxoplasmosis diagnosed by computed tomography (CT) guided percutaneous brain biopsy in a Haitian with AIDS.

Case report ● A 41-year-old Black Haitian male presented in September 1982 with fever and weight loss. After an extensive work-up, a diagnosis of miliary tuberculosis was established. He was transferred to a State hospital for therapy and responded well. In mid February 1983, just prior to discharge, hè developed mental deterioration, fever and grand mal seizures. He was started on antibiotics and anticonvulsants. Serial CT scans of the brain documented progressive multiple enhancing lesions in both hemispheres despite therapy. On neurologic examination he was awake but completely uncommunicative and stiff and rigid throughout his trunk and extremities. Due to the rapid clinical deterioration, very aggressive appropriate antibiotic or antitubercular therapy was deemed necessary. The current CT scan (Fig. 1) obtained prior to biopsy shows three definite enhancing lesions. The largest is in the right basal ganglia posterior to the caudate nucleus which is associated with edema producing mass effect and a mild midline shift. Additional smaller lesions were present in the high subcortical areas of the left parietal and right parieto-occipital regions. A CT guided biopsy of the brain was decided to be the most efficacious means of determining the nature of these lesions. The right parieto-occipital lesion was decided to be most accessible for percutaneous biopsy. Using the Scout View from the GE 8800 CT scanner for guidance, the level of the image showing the lesion and the approximate AP location was marked for a site of bur hole placement. On the second day of admission, a right parietal bur hole was made in the operating room and a needle biopsy of this lesion was performed under direct CT guidance (Fig. 2) in our mobile scanning unit.

Microscopic sections confirmed a pathologic diagnosis of toxoplasmosis. He was started on pyrimethamine and sulfadiazine by nasogastric tube and continued on antituberculous therapy. He improved clinically, became communicative and afebrile, but had significant residual left sided spasticity. Follow-up CT scans showed marked improvement in lesion size and degree of mass effect.

In late March he aspirated and developed profound respiratory insufficiency requiring intubation and ventilatory assistance and was placed on broad spectrum antibiotics, however, he did not respond and died. Lymphocyte sub-set studies were positive for inversion of the T-Helper to T-Supressor ratio, supporting the clinical diagnosis of Acquired Immune Deficiency Syndrome.

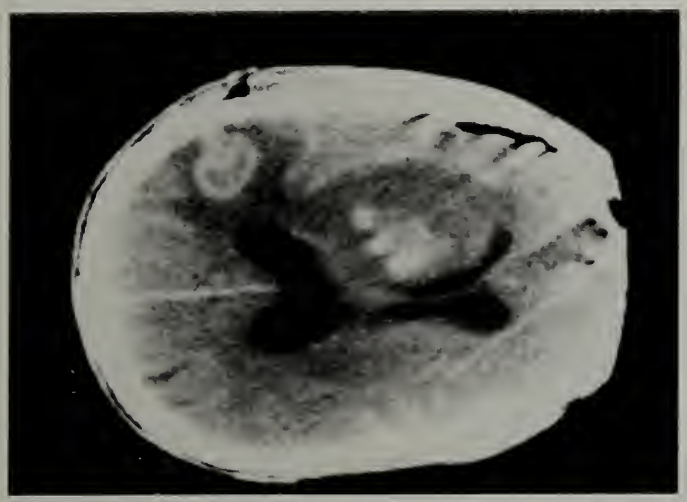


Fig. 1. — Pre-biopsy CT scan of the head with patient in left side down decubitus position shows two enhancing lesions in the right hemisphere with associated edema and mass effect. The largest is in the basal ganglia while the smaller is in the right subcortical parieto-occipital region. A bur hole has been placed adjacent to the peripheral lesion which accounts for the small amount of air noted anteriorly in the subdural location.

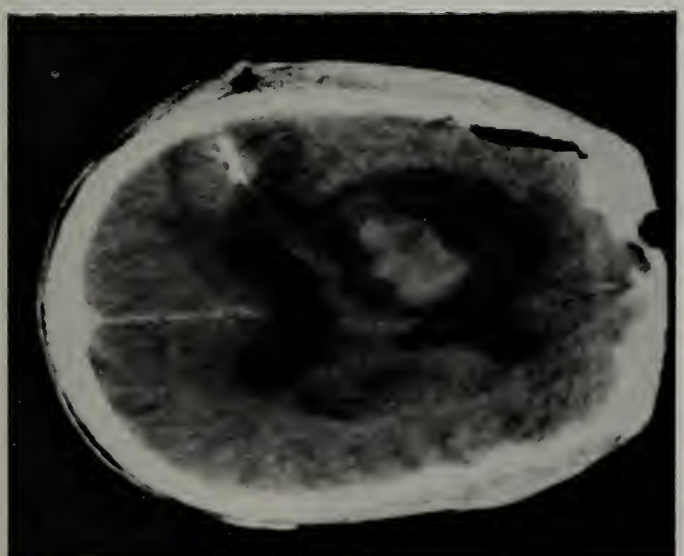


Fig. 2. — Using CT guidance, the biopsy needle is noted to lie within the small enhancing lesion in the right parieto-occipital region, confirming accurate needle placement.

Discussion • CT has proven to be a useful device for guiding a variety of percutaneous interventional procedures. CT provides a completely detailed image with both normal and abnormal anatomy, unimpaired by gas or bone. Because of its unique imaging properties, CT provides direct visualization of the biopsy instrument in the cross-sectional dimension. Percutaneous biopsy using CT guidance was first used for abdominal lesions[1,2] involving the liver, kidney and pancreas. Later, as techniques improved, the sites became more varied, such as the chest, extremities and central nervous system. Today there is virtually no area of the body inaccessible to CT guided biopsy.

Advances in CT now promise to revolutionize therapy by providing a safer, faster and more effective method for decompressing cystic lesions, aspirating and irrigating unilocular or multilocular intracranial abscesses and extra-axial collections, and for biopsy of intracranial lesions.[3] Pre-biopsy CT identifies the location, number, and degree of loculation of intracranial abscesses, documents the presence and thickness of an abscess capsule and delineates the relationship of the abscess to the cortical and ventricular surfaces. CT also evaluates ventricular size, as well as the extent of edema and mass effect.[4]

Despite advances in diagnostic techniques and widespread use of antibiotics, the incidence of brain abscess is not decreasing.[5] However, the spectrum of central nervous system infections is changing due to the immunosuppressed host. The organisms responsible for producing brain abscesses in compromised hosts differ from those that normally cause brain abscesses. These are more unusual opportunistic infections which are normally of low virulence and pathogenicity in man, incuding fungi, protozoa, bacteria and viruses. The type of organism can not be predicted by its CT appearance. Two major CT appearances of intracranial abscesses are (1) a poorly circumscribed area and (2) a localized encapsulated ring enhancement. The CT appearance of central nervous system infections seems to be a function of the host's reaction to it, rather than the specific infecting organism.[5] The typical ring contrast enhancement is seen in patients who wall off the infection to forestall rapid spread. If the patient is unable to localize the infection, the lesions are poorly circumscribed, are lower in density and usually exhibit little contrast enhancement. Toxoplasma gondii has produced both of these appearances.[5,6]

Disseminated toxoplasmosis, especially toxoplasmic encephalitis, is becoming a more frequently recognized complicating illness in the immunosuppressed host.[4,6,7] T. gondii usually causes subclinical and benign infection in the immunologically intact adult. The fulminant necrotizing encephalitis has been reported only in the immunocompromised

host. Because of its lack of specificity, it is believed that the role of CT in toxoplasmosis is to detect the lesions and localize the most accessible ones for immediate biopsy. Another role of CT is to monitor medical or surgical therapy by demonstrating progression or regression of the disease process.

The major value of CT for the neurosurgeon is the knowledge that the biopsy specimen has been taken with absolute certainty from directly within the lesion. In many of these situations it is highly unlikely that the pathologist will be able to provide a frozen section diagnosis. Without CT confirmation of exact needle placement in the lesion, multiple biopsies would be required, the incidence of complications and increased neurologic deficit much greater, and the lesion and diagnosis might still be missed inadvertently. An integrated team approach composed of the radiologist and neurosurgeon may now utilize CT to guide aspiration biopsy needles into central nervous system infections, including some not easily accessible to open biopsy.

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References

1. Haaga, J.R. and Alfidi, R.J.: Precise Biopsy Localization by Computed Tomography. Radiology 118:603-607, 1976.
2. Ferrucci, J.T. and Wittenberg, J.: CT Biopsy of Abdominal Tumors: Aids for Lesion Localization. Radiology 129:739-744, 1978.
3. Moran, C.J.; Naidich, T.P.; Gado, M.H., et al: Central Nervous System Lesions Biopsied or Treated by CT-Guided Needle Placement. Radiology 131:681-686, June 1979.
4. Post, M.J.D.; Chan, J.C.; Hensley, G.T., et al: Toxoplasma Encephalitis in Haitian Adults with Acquired Immunodeficiency Syndrome: A Clinical-Pathologic CT Correlation. AJR 140:861-868, May 1983.
5. Enzmann, D.R.; Brant-Zawadzki, M.; Britt, R.H.: CT of Central Nervous System Infections in Immunocompromised Patients. AJNR 1:239-243, May/June 1980.
6. McLeod, R.; Berry, P.F.; Marshall, W.H. Jr., et al: Toxoplasmosis Presenting as Brain Abscesses: Diagnosis by Computerized Tomography and Cytology of Aspirated Purulent Material. AMJ Med 67:711-714, October 1979.
7. Menges, H.W.; Fischer, E.; Valavanis, A., et al: Cerebral Toxoplasmosis in the Adult. J. Comput. Assist. Tomog. 3:413-416, June 1979.

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SPECIAL ARTICLE

Pediatrics in an academic health center

George T. Harrell, M.D.

It is indeed an honor to be asked to participate in this celebration of the founding of the Department of Pediatrics twenty-five years ago. Tremendous changes have occurred in the State, the University, and the community since 1958. The situation is quite different from January 1, 1954, when I came on campus to a shared office in Tigert Hall and was greeted with a parking ticket for stopping in the administrative parking lot with an out-of-state license tag on my car.

Historical background • The College of Medicine was authorized by the Legislature in 1949. Intense political maneuvering began as to where the school should be located, since discussions had implied that operating funds could go the first one opened. The University of Miami, in an incredibly short time, organized its school in 1952 and began teaching in the old servants' quarters of the Miami Biltmore Hotel. The Jackson Memorial Hospital, a large, urban tertiary care facility, was to be the clinical teaching unit. This setting dictated the initial character of that school's program.

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The University of Florida was the land grant college of the State with an enrollment at that time of only about 7,000, located in the small city of Gainesville, which had a population of about 25,000 and was surrounded by a conservative rural area. The program of the University was dominated by the Colleges of Agriculture and Engineering. President J. Hillis Miller obtained a grant of $96,500 from the Commonwealth Fund of New York to determine what type of medical school should be established. The two-year study, done by University faculty with outside consultants, was completed in 1954 and led to the publication of the Medical Center Study Series. The conclusions confirmed what already was known to the profession in the State. The number of physicians in rural areas and small towns had steadily declined over the years, as it had nationally. Medical care was inadequate, especially in north central and western Florida. The need was for broad, generally trained doctors. The study made no recommendations for the types of specialists that should be trained, or their numbers.

A 1953 appropriation of $5 million provided for the construction of a teaching building for the Colleges of Medicine and Nursing. Geographically, Gainesville was ideally located. The nearest medical schools were some distance away, in Augusta, Atlanta, New Orleans, and the new one in Miami. Residency programs were few in the State and were located in Miami, Jacksonville, Tampa, and St. Petersburg. A number of trained specialists were in practice in Jacksonville, with a few in Gainesville, including two pediatricians.

Planning for the college • The Dean faced three problems which had to be addressed before the school could open on schedule in 1956. How could

undergraduate medical student education be integrated into the existing university programs? Which residency training programs should be established, with how many graduates in each? What was the role of faculty in the delivery of patient care in addition to their teaching duties?

Some positions had already been taken which the new school had to follow. The legislature made clear the role was to train doctors for the entire State. Emphasis was to be on practice, which was to include all members of a family. The construction appropriation was only for a medical sciences building. No authorization had been made for a teaching hospital, although one had been included in the architectural planning since 1954. By 1956, an appropriation of $8.6 million was made for the initial construction. It was to serve the entire State and not to become the charity hospital for Gainesville and Alachua County.

The University had indicated that the College of Medicine was to be integrated with established general programs around the theme of human biology.

The University had indicated that the College of Medicine was to be integrated with established general programs around the theme of human biology. A team approach was to be taken to education and patient care. Existing resources were to be used, such as the Faculty of Science, the P. K. Yonge Laboratory School, the Florida Center of Clinical Services, and the Sunland Training Center. Research tools already on campus were to be used. The University was committeed to very large, central computers which should be used on a time-sharing basis. No small, dedicated, special purpose computers were permitted. The one electron microscope was in the College of Engineering run by a research professor. Isotope-counting equipment was in the same college. The feeling was that these types of resources could serve the medical school needs and that doctors were not sufficiently trained to use such sophisticated instruments. Animals could be used and housed in the medical school, but there must be no competition with the program in veterinary science in the College of Agriculture. No veterinary school was envisioned at that time. If marine forms were needed, the small laboratory on Lighthouse Key, reached by outboard motorboat from Cedar Key, could be used.

A series of articles describing these problems and their ultimate solutions was published over the years in the journals of the Florida and American Medical Associations. For those who prefer more informal accounts, oral history tapes have been made and are available in the State Museum on campus.

Medical societies had been involved from the earliest discussions of the need for and location of a school. The Florida Medical Association, based in Jacksonville, had for many years run from there a continuing education program in conjunction with the graduate school of the University. The FMA backed plans for a medical school and wanted it located in Jacksonville. When the decision was made to place it on campus rather than in a large metropolitan area, they agreed and in a few years relinquished their educational program to the new school in Gainesville. The members of the Alachua County Medical Society, with a few exceptions, greatly feared that their practices would be reduced, if not taken over, by the clinicians in the school. Some wanted senior faculty appointments, but to continue practice in their town offices. The University with its students, faculty, and staff was the largest industry in town. The local doctors always had cared for these people as private patients, mostly by self-referral. They strongly insisted that county residents be seen in the planned teaching hospital only by referral. The aging county hospital was small and had no house officers. Its staff permitted faculty access only for consultations, not for admitting patients, which the school did not intend to permit.

Solutions • The Dean was appointed in November, 1953. President Miller died within weeks and before the Dean came in residence. The Acting President announced he was not a candidate for the permanent position. He had been reluctant to see the medical school come because of fear that its needs would reduce support of ongoing programs. Later he reversed himself on both positions, became President of the University of South Florida in Tampa, and established a medical school there.

Because of the uncertainties of policies at top administrative levels, the Dean wrote a basic philosophy for the school to make sure everyone understood what would be attempted. It was publicized in *The Journal of the Florida Medical Association, Inc.*, *University of Florida Alumni* magazine, *Journal of the American Medical Association*, and other media.

A young faculty was recruited with proven interest and capability in teaching as the first requirement. They had to have shown research potential with sound publications. An excellent basic science faculty was recruited promptly. Some difficulty was encountered with clinical faculty in the absence of assurance of a teaching hospital. The first effort was to get the Professor of Medicine here two years before his clinical work would begin. He would teach in the University and show that medical faculty

were interested in general education and not simply in seeing patients. An amusing incident occurred when the ultimate incumbent first was interviewed. The foundation for the Medical Sciences Building was designed as a concrete boat to rest on a sea of sand. The contract was let separately to save time, and the work was completed promptly. The superstructure contract was let to a firm which came on campus, built a construction office shack, and never appeared again. The state architect had failed to include a starting date. The foundation collected several feet of water and head-high weeds surrounded it. When I took the candidate there, he took one look, said there would never be a school here, and got back on a plane going north.

The Professor of Surgery was recruited to enable basic animal research to be started before patients were admitted. Obstetrics and Gynecology was delayed slightly to permit the professor to complete some high-altitude research on placental transfer. Psychiatry was to teach in the early years of the medical curriculum and up campus. The appointment in pediatrics came later. Three of the initial chairmen, including pediatrics, were only 33 years old.

The curriculum was planned to permit unconventional teaching within a conventional framework. The problems in the early years were encountered locally. We had none with the accrediting agencies. University decisions did not allow appointment of medical faculty in behavior or humanities. These fields were considered liberal arts disciplines and, if needed, the school should use faculty from arts and sciences or the graduate school. No primary care program was permitted in Gainesville because of the position taken by the legislature and medical societies, with which the University agreed. Preceptorships were arranged in several small towns, but the distances did not permit direct faculty supervision of the teaching.

From the beginning, a broad approach was made to the medical student. Emphasis was placed on self-education, which should continue life-long, and on problem-solving. Study cubicles, the first in any medical school, were provided each student to dramatize the approach and help establish a pattern of learning. The curriculum would point the student to be a comprehensive, compassionate physician first, before he decided on his ultimate field of practice. He should look at disease in the family setting, the factors contributing to the illness, and the resources available for its treatment.

Considerable emphasis was placed on ambulatory care, which was conceived as the wave of the future. The ambulatory patient care bed wing was the first built as an integral part of a U.S. teaching hospital. A family member could stay with the patient, a concept especially useful in pediatrics. We picked the wrong location, an upper floor that restricted access to meals in the first floor cafeteria and to outdoor areas. Unexpected resistance was encountered with third-party payers, even though charges were substantially lower than on traditional bed floors. The faculty persisted in efforts to use the beds for acute care, which required a level of nursing and support services not provided.

The first ambulatory surgical suite in the United States, separate from the major operating rooms, was built in the hospital.

The first ambulatory surgical suite in the United States, separate from the major operating rooms, was built in the hospital. Ambulatory surgery now is accepted practice even in clinics outside of hospitals. The faculty failed to use it as planned and considered every surgical procedure a major one requiring all the traditional ritual. The suite was expected to be useful safely for many pediatric procedures.

The initial concept of the outpatient area was as a general clinic, not a general medical clinic, as it often has been interpreted. After examination, patients would be referred to appropriate specialty clinics of the various departments, if necessary. Faculty, including the professors in surgery, obstetrics, and psychiatry, saw any patient assigned them, deliberately not one in their specialty field. This approach stimulated breadth of teaching, particularly in the clinical chairmen who enjoyed it. The examining room settings were all the same and had a home flavor. A problem arose in how to incorporate pediatrics, especially with the examining rooms. Discussions took place as to what age children appropriately should be seen in a general clinic as they would in a family physician's office in any community. The Dean proposed the age at which children started school, with all infants and younger patients seen directly by pediatrics. No agreement could be reached, so the outpatient department became a traditional one, with pediatrics the first to have separate facilities.

A problem was how to teach family medicine in a real home setting. The Dean requested of the President permission to use one of three Florida Veterans' housing units on campus. University stipends for graduate students living in them were below the poverty level set by the Florida Medical Association when physicians should not charge fees. It was suggested that pediatrics administer the program, since many families had children and this student group was known to have low incomes. The University refused the request because of resistance from the County Medical Society. The experiment

with the pediatrician as the physician for the entire young family never was conducted.

For acute care in the hospital, residency training programs in general specialty fields were planned. The need for special facilities for certain patients was recognized. The initial planning always had provided a separate pediatric floor and nurseries. Teaching apartments were built on each nursing floor, the first in any major hospital. This innovation proved to have been designed on the wrong scale. The rooms were too small for their intended purpose. They were planned for use before discharge of patients, to instruct patient and a family member in continuing care in the home with equipment found there. Faculty and staff failed to accept the use for education and subverted them for lounges and on-call house staff sleeping.

The team approach to acute and ambulatory care started with expansion of the Florida Center of Clinical Services from a facility for students oriented toward speech, hearing, and psychological testing, into the College of Health-Related Services. This college, the second in this country by only a few months, permitted university level training in the original fields plus physical and occupational therapy. As the programs matured, the term "professions" was substituted for "services" in the title.

The programs and ideas described above were the foundation 25 years ago for the ultimate departments, including pediatrics, which have developed over the years.

The future • An unanswered question is who will give primary care? Are physicians necessary — a critical point medical educators in this country have not faced. What is the role of nurse practitioner, physician's assistant or other new types such as the "barefoot doctor" in rural areas where MDs are not settling? The experience of a number of Third World countries was related at an international conference in Bellagio, Italy. The papers, collected in a book, make clear that satisfactory solutions for the countries represented have been devised independently of the doctor.

Will the trend of the last few decades continue, with the MD becoming more and more a superspecialist? This trend results in a splintering of patient care with no one clearly in charge. Specialization evolves from increasing dependence on sophisticated equipment and technology which requires a separate, dedicated, trained staff to operate and maintain. The support requires the superspecialist to be based in a hospital or large clinic. Pediatrics is following this trend with separate programs in surgery, psychiatry, hematology, and other fields. Patients and educators fear the gradual loss of human, personal touch.

The answers will come with what the public will accept and demand.

The chief causes of death have changed dramatically during the lifetime of many physicians still active. Infectious diseases, the great killers of the past, are under control, except for the viruses. Smallpox, though, appears to have been eradicated. The control has been achieved by chemotherapy and by prevention, both by public health measures and personal immunizations in which pediatrics has played a major role. The chief killers now are the chronic illnessess — heart disease, stroke, cancer, and, in children, accidents and suicide. The clues we have to the causation of chronic illnesses are found in the lifestyle of patients. The factors are diet, exercise, stress, tobacco use, alcohol abuse and drug use, both prescribed and self-administered. We do not have the basic biologic information, which will require many years of research to obtain. We also need to know much more about behavior as a basic biologic phenomenon.

What is the role of pediatrics? You have made major contributions to acute problems through such developments as premature and poison control centers and child seats to reduce deaths from automobile accidents, still a great killer in the young. What can be done to delay or prevent the chronic illnesses? At what age do they start? Most have genetic components; evidence of atherosclerotic staining of aortas can be detected in childhood autopsies, demonstrating that the processes start in the young. The pattern of lifestyle is set early in the family. A greater role is foreseeable for the pediatricians themselves, or members of their staffs, in education of parents and their families. How much should the child be taught, when, and who does it best? Studies at Hershey before the school opened showed that if money were scarce, homemakers would put it into food before spending it on the doctors, who came in third in their priorities. In the coming years, the moral and ethical problems faced by the doctors and families in their practices will loom greater than the scientific ones.

In the long view, pediatrics will survive as a specialty, certainly in the neonatal period and for small children, since no one else does it as well.

Delivered at the 25th Anniversary Celebration of the Department of Pediatrics, University of Florida College of Medicine, Gainesville, September 30, 1983.

• Dr. Harrell, 2010 Eastridge Rd., Timonium, Maryland 21093

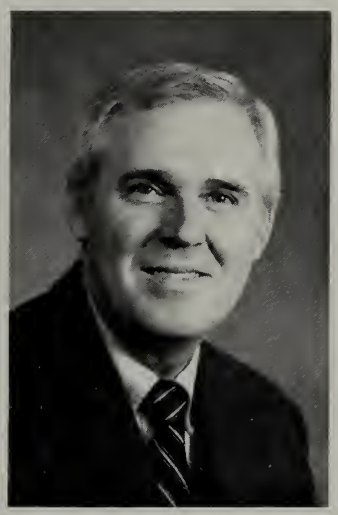
FLORIDA MEDICAL

DEPARTMENTS

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NOTES & NEWS

Dr. Dockery elected President of Florida OB/GYN Society



J. Lee Dockery, M.D., Professor of Obstetrics and Gynecology and Associate Dean of the University of Florida's College of Medicine, is the new President-Elect of the Florida Obstetric and Gynecologic Society.

Dr. Dockery was elected to office during the Society's annual meeting at Sandpiper Bay, Florida. He will assume responsibilities as President in December of this year and will direct activities of the 1000-member organization throughout 1985.

Dr. Dockery, who also is current President of the Florida Medical Association, will succeed F. Lee Howington, M.D., of Fort Myers as President of the Florida Obstetric and Gynecologic Society.

A native of Hot Springs, Arkansas, Dr. Dockery earned his M.D. degree in 1957 from the University of Arkansas School of Medicine at Little Rock. He completed residency training in his specialty at Jackson Memorial Hospital in Miami and was certified by the American Board of Obstetrics and Gynecology. Following two years of service as a U.S. Air Force medical officer in Spain, he joined the part-time faculty of the Department of Obstetrics and Gynecology at the University of Miami School of Medicine. He remained there, and participated in private practice of OB/GYN in Miami until 1975 when he was appointed to the faculty of the University of Florida College of Medicine. He has served as Associate Dean of the College since 1978.

Dr. Selander named Florida's "Family Physician of the Year"

The Florida Academy of Family Physicians has designated Guy T. Selander, M.D., of Jacksonville, as Florida's "1984 Family Physician of the Year." Dr. Selander, Chairman of the FMA-FMF Committee on Impaired Physicians, will compete with other physicians throughout the country for American Family Physician of the Year honors. That award will be announced next October during the Annual Meeting of the American Academy of Family Physicians. Dr. Selander is a Past President of the FAFP and of the Duval County Medical Society.

Former FMA President William C. Roberts, M.D., dies

Former FMA President William C. Roberts, M.D., of Panama City has died at age 78. A graveside service was held on February 20 in Panama City, and the family requested that in lieu of flowers donations be made to the Past Presidents Fund of the Florida Medical Foundation. Dr. Roberts, who headed the FMA in 1957, was a native of Alabama. He graduated from the University of Tennessee Medical School and established his practice as an obstetrician and gynecologist in Panama City in 1932. His wife and son are among survivors.

110th ANNUAL MEETING

Final plans coming together for Scientific Program

The 110th Annual Meeting of the Florida Medical Association promises to offer another outstanding and valuable scientific program. Headlining the program will be an FMA sponsored symposium on "The Health of the Public" Friday morning, May 4th, featuring Edward N. Brandt, M.D., Assistant Secretary, Department of Health and Human Services (HHS) and James Mason, M.D., Director, Center for Disease Control. Calvin W. Martin, M.D., Chairman of the Committee on Medical Education and Orris O. Rollie, M.D., Chairman of the Subcommittee on the Annual Meeting Scientific Program encourage all members to attend this outstanding symposium.

As in the past, 20 hours of AMA Category I CME credits will be available to program registrants. See you at the Palace Hotel, Lake Buena Vista, May 2-6, 1984.

Listed below is the preliminary scientific program. The complete program will be included in the April issue. Specific times for each section and room assignments will be included in the program manual provided to each registrant.

SECTION ON ALLERGY AND IMMUNOLOGY

(Co-sponsored by Florida Allergy Society)
Saturday, May 5, 1984—8:25 a.m. to 12:45 p.m.
Norman H. Wasserman, M.D., Plantation
Program Chairman

"**Drug Allergy,**" Roger W. Fox, M.D., Tampa
"**The Role of Calcium Blockers in Bronchial Asthma,**" Adam Wanner, M.D., Miami Beach
"**Stinging Insect Allergy — Current Concepts and Controversies,**" Robert E. Reisman, M.D.
"**Role of IgG Antibodies in Human Allergic Disease,**" Robert E. Reisman, M.D.
"**Immunology of Aging,**" John J. Stablein, M.D., Tampa
"**Asthma in Pregnancy,**" Milton Braunstein, M.D., Ft. Lauderdale
"**IgG — Subclass Deficiency,**" R. Lawrence Siegel, M.D.

SECTION ON ANESTHESIOLOGY

(Co-sponsored by Florida Society of Anesthesiology)
Friday, May 4, 1984—1:00 p.m. to 5:00 p.m.
Lawrence S. Berman, M.D., Gainesville
Program Chairman

"How to Suitproof Your Anesthetic Practice"

"**A Plaintiff's Attorney,**" William Colson, Esq., Miami
"**A Defense Attorney,**" Leon Handley, Esq., Orlando
Break
"**Insurance Perspective,**" Mr. Bob White, Director of Claims and Loss Prevention, Physicians' Protective Trust Fund
"**An Anesthesiologist's Point of View,**" Arthur S. Keats, M.D., Professor and Chief, Division of Cardiovascular Anesthesia, Texas Heart Institute, Houston, Texas
Panel Discussion

SECTION ON CHEMICAL DEPENDENCY

(Co-sponsored by Florida Medical Foundation Committee on Impaired Physicians)
Thursday, May 3, 1984—1:30 p.m. to 4:30 p.m.
Dolores Morgan, M.D., Miami
Program Chairman

Welcome — Guy T. Selander, M.D., Chairman
"**The Disease Concept of Alcoholism,**" David L. Ohlms, M.D., Psychiatrist
Break
"**Cocaine — The Craze of the 1980s,**" Charles V. Wetli, M.D., Deputy Chief Medical Examiner of Dade County, and Clinical Associate Professor of Pathology at the University of Miami School of Medicine, Miami
Discussion

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Thoracic Society and Florida Chapter, American College of Chest Physicians)
Thursday, May 3, 1984—1:00 p.m. to 4:30 p.m.
John R. Ibach Jr., M.D., Jacksonville
Mark Snider, M.D., Miami
Program Chairmen

Richard G. Connar, M.D., Tampa
Moderator

"Lung Cancer: Current Update"

"**Current Trends in Epidemiology of Lung Cancer,**" William Weiss, M.D., Philadelphia, Pennsylvania
"**Detection, Diagnosis and Clinical Staging,**" Allan L. Goldman, M.D., Tampa
"**Surgical Treatment,**" Edward J. Beattie, M.D., Miami
"**Radiotherapy,**" Shyam B. Paryani, M.D., Jacksonville
"**Chemotherapy,**" Oleg S. Selawry, M.D., Miami
Panel Discussion

SECTION ON COLON AND RECTAL SURGERY

(Co-sponsored by Florida Society of Colon and Rectal Surgeons)
Friday, May 4, 1984—1:00 p.m. to 5:30 p.m.
Harvey A. Shub, M.D., Orlando
Program Chairman

"**Pubo Rectalis Plications, Sphincteroplast for Anal Incontinence,**" Emmet Ferguson Jr., M.D., Jacksonville
"**Silastic Implant for Anal Incontinence,**" Sergio Larach, M.D., Orlando
"**Repair of High Rectal Vaginal Fistulas,**" Nelson Brouillette, M.D., Winter Park
"**Medical Colostomy and Its Use in Repair of Rectal Vaginal Fistulas,**" Harvey Shub, M.D., Orlando
"**Subtotal Colectomy, Rectal Mucousectomy and Ileal-anal Anastomosis,**" Harvey Garber, M.D., North Miami Beach

SECTION ON DERMATOLOGY

(Co-sponsored by Florida Society of Dermatology)
Friday, May 4, 1984—2:00 p.m. to 5:30 p.m.
Saturday, May 5, 1984—8:30 a.m. to 12:00 p.m.
Sorrel S. Resnik, M.D., Miami
Henry W. Menn, M.D., Miami
Program Chairmen

Friday, May 4

"**Surgical and Non-surgical Pearls,**" (Panel Discussion), Moderator: Sorrel S. Resnik, M.D. Panelists: Hiram Sturm, M.D.; Terrence Cronin, M.D., Melbourne; John Hicks, M.D., Coral Gables and Morris Waisman, M.D., Tampa
"**Dermatopathology Clinical Conference,**" Neal Penneys, M.D., Ph.D., Professor, Department of Dermatology and Cutaneous Surgery, University of Miami School of Medicine; Alexander Kowalczyk, M.D., Assistant Professor, Department of Dermatology and Cutaneous Surgery, University of Miami School of Medicine, Miami

Saturday, May 5

"**Consultations in Dermatology,**"—**Norman Fogel, M.D., Memorial Lectureship,** Walter B. Shelley, M.D., Ph.D., Professor of Dermatology, Medical College of Ohio, Toledo

"Stimulated Mitotic Counts in Patients with Psoriasis Versus Controls," M. Joyce Rico, M.D., Second Year Resident, Department of Dermatology and Cutaneous Surgery, University of Miami School of Medicine, Miami

"Office Axillary Surgery for Treatment of Hidradenitis Suppurativa and Axillary Hyperhidrosis," — Ruth Dugan Memorial Lectureship in Cutaneous Surgery, Hiram Sturm, M.D., Clinical Professor of Dermatology, Emory University, Atlanta, and President, American Society for Dermatologic Surgery

Break

"Human T-cell Leukemia Lymphoma Virus," Lionel Resnick, M.D., Second Year Resident, Department of Dermatology, Mount Sinai Medical Center, Miami

Presentation—Second Year Resident, Department of Dermatology, University of South Florida, Tampa

"The Clinical and Serological Manifestations of Lupus Erythematosus," — Wiley Sams, M.D., Lectureship, W. Mitchell Sams Jr., M.D., Professor and Chairman, Department of Dermatology, University of Alabama, Birmingham

SECTION ON ENDOCRINOLOGY

(Co-sponsored by Florida Endocrine Society)
Friday, May 4, 1984 — 1:00 p.m. to 5:00 p.m.
Samuel E. Crockett, M.D., Orlando
Program Chairman

"Thyroid Biopsies and Thyroid Cancer," Joel I. Hamburger, M.D., FACP

"The Use of Thyroid Biopsy in Private Practice in Florida," Jack Baskin, M.D., Orlando

Break

"Thyroid Lymphoma," Joel I. Hamburger, M.D., FACP

Panel Discussion

SECTION ON DIABETES

(Co-sponsored by American Diabetes Association, Florida Affiliate and Florida Endocrine Society)
Thursday, May 3 — 1:00 p.m. to 5:30 p.m.
Edward Biederman, M.D., Ft. Lauderdale
Program Chairman

"Pathophysiology Update," Harold E. Lebovitz, M.D., Professor of Medicine, Chief of Endocrinology, S.U.N.Y. Downstate Medical Center, Brooklyn, New York

"Diabetic Therapy in 1984," Harold E. Lebovitz, M.D.

"Diabetes in Pregnancy," Kay F. MacFarland, M.D., Professor of Medicine, Associate Dean of Continuing Medical Education, University of South Carolina School of Medicine, Columbia, South Carolina

"Diabetic Eye Disease," Guy O'Grady, M.D., Chief of Ophthalmology, Miami Veterans Medical Center, Associate Professor of Ophthalmology, University of Miami School of Medicine, Miami

Panel Discussion

SECTION ON FAMILY MEDICINE

(Co-sponsored by Florida Academy of Family Physicians)
Thursday, May 3 — 1:30 p.m. to 4:30 p.m.
Joseph E. Holland, M.D., Leesburg
Program Chairman

"Toxic Environmental Substances and Concerns of Their Effects on Public Health," John E. Davies, M.D., Professor and Chairman, Department of Epidemiology and Public Health, University of Miami School of Medicine, Miami

"Histamine Blockers," Arvey I. Rogers, M.D., Professor of Medicine, University of Miami School of Medicine, Miami

"Snake Bites," T. Byron Thames, M.D., Practicing Physician and FMA Past President, Orlando

"Medical Dissolution of Cholesterol Gallstones," Eugene Schiff, M.D., Professor of Medicine, Chief, Division of Hepatology, Coordinator for Liver Diseases, University of Miami School of Medicine, Miami

SECTION ON INTERNAL MEDICINE

(Co-sponsored by American College of Physicians, Florida Region and Florida Society of Internal Medicine)
Wednesday, May 2, 1984 — 1:00 p.m. to 4:15 p.m.
Roy H. Behnke, M.D., FACP, Tampa
Program Chairman

1983 and Beyond: Therapy of Common Medical Disorders

"Respiratory Disease Management," Allan L. Goldman, M.D., Professor of Medicine and Director, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine, University of South Florida College of Medicine, Tampa

"Antibiotic Management," Charles P. Craig, M.D., Professor of Medicine and Director, Division of Infectious and Tropical Diseases, Department of Internal Medicine, University of South Florida College of Medicine, Tampa

Discussion

"Cardiologic Problem Management," Stephen P. Glasser, M.D., Professor of Medicine and Director, Division of Cardiology, Department of Internal Medicine, University of South Florida College of Medicine, Tampa

"Rheumatologic Disease Management," Bernard F. Germain, M.D., Associate Professor of Medicine and Director, Division of Rheumatology, Department of Internal Medicine, University of South Florida College of Medicine, Tampa

Discussion

SECTION ON NEUROSURGERY

(Co-sponsored by Florida Neurosurgical Society)
Saturday, May 5, 1984 — 8:30 a.m. to 10:30 a.m.

Arthur L. Day, M.D., Gainesville
Program Chairman

"ICU Management of the Neurosurgical Patient"

"Head Injury and ICP," P. Villanueva, M.D.

"Spinal Injury," Barth A. Green, M.D., Miami

"Subarachnoid Hemorrhage and Vasospasm," Arthur L. Day, M.D., Gainesville

"Evoked Potential Monitoring," William A. Friedman, M.D., Gainesville

Break

SECTION ON OCCUPATIONAL MEDICINE

(Co-sponsored by Florida Occupational Medical Association)
Friday, May 4, 1984 — 7:30 a.m. to 9:00 a.m.
Maurie Pressman, M.D., Clearwater
Program Chairman

"Honeywell's Program for Health Care Management," John Burns, M.D., Medical Director, Honeywell, Inc., Minneapolis, Minnesota

"On Housing Health, Safety and Employee Assistance in the Same Organizational Department — The Johnson & Johnson Experience," Ken Krieger, Director, Department of Health and Safety, Critikon, Inc., Tampa

"Joining Health and Mental Health Prevention: Employee Enhancement Programs," David E. Stenmark, Ph.D., Behavioral Medicine, Intervention Systems, Clearwater

Occupational Stress: Identification and Management," Emmett

B. Ferguson, M.D., Medical Director, Occupational Medicine, Environmental Health Services, Kennedy Space Center, Florida

SECTION ON OPHTHALMOLOGY

(Co-sponsored by Florida Society of Ophthalmology, Inc.)
Friday, May 4, 1984—1:00 p.m. to 5:00 p.m.
Saturday, May 5, 1984—8:30 a.m. to 12:30 p.m.
Harry W. Flynn Jr., M.D., Miami
Program Chairman

Friday, May 4

"Evaluation and Management of Dislocated Lenses," Harry W. Flynn Jr., M.D., Miami
"Advances in Vitreo Retinal Microsurgery," Mark S. Blumenkranz, M.D., Clearwater
"Macular Disease in Diabetic Patients," Frederick Ferris, M.D., Tampa
"Macular Degeneration — A Treatable Disease," Robert S. Murphy, M.D.
Break
"Common Uveitis Problems," William W. Culbertson, M.D., Miami
"Microbial Keratitis," Richard Abbott, M.D.
Panel Discussion

Saturday, May 5

"Ocular Manifestations of Dermatologic Disease," Richard Abbott, M.D.
"Infectious Diseases of the Retina I," William W. Culbertson, M.D.
"Infectious Diseases of the Retina II," Mark S. Blumenkranz, M.D.
Break
"Application of DRS Data to Clinical Practic," Frederick Ferris, M.D.
"Common Macular Disease," Robert P. Murphy, M.D.
"Common Uveitis Problems," William W. Culbertson, M.D.
"Advances in Vitreo Retinal Microsurgery," Mark S. Blumenkranz, M.D.
"Management of Intraocular Foreign Bodies," Harry W. Flynn Jr., M.D.

SECTION ON PATHOLOGY

(Co-sponsored by Florida Society of Pathologists)
Friday, May 4, 1984—2:00 p.m. to 5:00 p.m.
Gert G. Larbig, M.D., West Palm Beach
Program Chairman

"Cost Effective Laboratory Utilization Under the DRG Prospective Payment System," George D. Lundberg, M.D.
Break
Presentation of Awards of Florida Society of Pathologists
"The Importance of the Medical Examiner for the People's Health," Wallace Graves, M.D., Fort Myers

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

(Co-sponsored by Florida Society of Physical Medicine and Rehabilitation)
Saturday, May 5, 1984—9:00 a.m. to 11:30 a.m.
Luis de Lerma, M.D., St. Petersburg
Program Chairman

"Total Joint Replacement — Orthopaedic and Rehabiliation Medicine Approach," J.R. de Andrade, M.D., The Woodruff Medical Center, Atlanta, Georgia
Break
"Diagnostic Related Groups — Their Impact on Private Practice," A.J. Pasach, M.D. and Associates, Tampa

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY

(Co-sponsored by Florida Society of Plastic and and Reconstructive Surgeons)
Saturday, May 5, 1984—8:00 a.m. to 11:00 a.m.
M. Felix Freshwater, M.D., Miami
Program Chairman

"Eyelid and Adnexal Reconstruction," James H. Carraway, M.D., Professor of Plastic Surgery, Eastern Virginia University School of Medicine, Norfolk, Virginia
"Rational Approach to Soft Tissue Coverage of the Lower Extremity," M. Felix Freshwater, M.D., Assistant Professor of Plastic Surgery, University of Miami School of Medicine, Miami

SECTION ON PREVENTIVE MEDICINE

(Co-sponsored by Florida Society of Preventive Medicine)
Saturday, May 5, 1984—9:00 a.m. to 12:00 p.m.
Robert K. Wilson, M.D., Pensacola
Robert D. May, M.D., New Port Richey
Program Chairmen

Greetings from the Program Chairmen
"State of the Public's Health," Stephen King, M.D., Staff Director, Health Program Office and State Health Officer
"Financial Strategies for Health Services," James Howell, M.D., Deputy Secretary, Department of HRS, Tallahassee
"Practical Guide to Nutrition," Thomas E. Grow, Ph.D., Associate Professor, Department of Basic Dental Science, University of Florida College of Medicine, Gainesville
Break
"Infectious Disease Update," John Witte, M.D., M.P.H., Program Administrator, Preventive Health Services, Department of HRS
"The Impact of the Florida Drunk Driving and Child Restraint Laws on the Health of the Public," Sergeant Robert M. Kirby, Public Information, Safety Education Office, Florida Highway Patrol
"What a Piece of Work is Man" Major Public Health and Preventive Medicine Issues in USA Today, (Slide Presentation), Robert May, M.D. and Ray Cowart, M.D.

SECTION ON RADIOLOGY

(Co-sponsored by Florida Radiologic Society, Inc.)
Friday, May 4, 1984—1:00 p.m. to 4:45 p.m.
Saturday, May 5, 1984—7:00 a.m. to 5:00 p.m.
A.L. Maloy, D.P.A., Tallahassee
Ernest Wollin, M.D., Tallahassee

Friday, May 4

"Radiologic Equipment Selection, Purchase and Maintenance," Thomas Thompson, M.D., Miami
Break
Continuation of above seminar

Saturday, May 5

Continental Breakfast
"Percutaneous Removal of Kidney Stones," James Caridi, M.D.
"Percutaneous Uses of Absolute Alcohol," Gregg S. Nanni, M.D.
"Percutaneous Biliary System Decompression," David M. Pearse, M.D.
Break
"C.T. Discography," Jim Barnes, M.D.
"Neonatal Head Ultrasound," Eve Jehle, M.D.
"Chemodactomas," Norm Clinkscales, M.D.
Buffet Luncheon
"Legal Aspects on Radiological Practice," Joan Wollin, Attorney at Law

Break
"Resident's Workshop — Socioeconomic Aspects of Radiological Practice," Sylvan Sarasohn, M.D.

SECTION ON RHEUMATOLOGY

(Co-sponsored by Florida Rheumatology Society)
Thursday, May 3, 1984—1:30 p.m. to 5:00 p.m.
M.F. Mass, M.D., Jacksonville
Program Chairman

"Arthritis in Childhood," Jerry C. Jacobs, M.D., Professor of Clinical Pediatrics, Director, Pediatric Rheumatology, Columbus University
"Kawasaki Disease," Jerry C. Jacobs, M.D.
"Update on AIDS," N. Lawrence Edwards, M.D., Assistant Professor of Medicine, University of Florida, Gainesville

SECTION ON SURGERY

(Co-sponsored by International College of Surgeons)
Saturday, May 5—10:00 a.m. to 12:00 p.m.
Robert H. Hux, M.D., Leesburg
Program Chairman

"Evaluation of the Trauma Patient," David L. Sustarsic, M.D., Lieutenant Commander, U.S. Naval Reserve, Lieutenant Commander, Medical Corp., U.S. Naval Reserve, Chief of Surgery, U.S. Naval Hospital, Lemoore, California, Instructor in Advanced Trauma Life Support

SECTION ON SURGERY

(Co-sponsored by Florida Chapter, American College of Surgeons and Florida Association of General Surgeons)
Friday, May 4, 1984—2:00 p.m. to 4:00 p.m.
David H. Shapiro, M.D., Belleair
William Hartley, M.D., Ft. Lauderdale
Program Chairmen

"Socio-Economic Issues in Medicine"

"Prospective Pricing and Physicians," Donald Young, M.D., Executive Director, Prospective Payment Assessment Commission, Health Care Financing Administration
"Prospective Reimbursement and Physicians," Richard C. Dever, M.D., Medical Director and Vice President, Medical Affairs, Blue Cross/Blue Shield of Florida
"Changing Practice Environment," James Haug, Director, Department of Surgical Practice, American College of Physicians
"HMOs and PPOs — The Florida Scene," Harvey Matoren, Vice President, Alternative Delivery Systems, Blue Cross/Blue Shield of Florida
Resident Paper Competition
Presentation of winning scientific papers from resident physicians
Panel Discussion

SECTION ON THORACIC AND CARDIOVASCULAR SURGERY

(Co-sponsored by Florida Society of Thoracic and Cardiovascular Surgeons)
Saturday, May 5, 1984—8:00 a.m. to 11:00 a.m.
James A. Alexander, M.D., Gainesville
Program Chairman

"Individual Use of Cardioplegia with Case Presentations of Long Ischemic Time," Richard Perryman, M.D., Jacksonville; Ernest Traad, M.D., Miami; Dennis Pupello, M.D., Tampa; Gordon Moor, M.D., Lakeland, and James A. Alexander, M.D., Gainesville
"State of the Art — Myocardial Protection," Robert A. Guyton, M.D., Professor of Surgery, Emory University, Atlanta, Georgia
Discussion

DEAN'S MESSAGE

"Old Genetics" for adults in everyday medicine

Currently physicians as well as the public are saturated with news of genetic engineering, prenatal diagnosis, gene therapy, and even production of "test-tube" babies. At the University of Miami we too are engaged in the "new genetics." But quite apart from these dramatic advances, what are the practical applications of the "old" genetics in everyday medicine? Consider these "old genetic" facts:

1. Genetic disorders are common in the aggregate, however rare they may be individually.
2. For each index case of a genetic disorder multiple family members may be at risk.
3. Many genetic disorders are environmentally dependent and can be prevented, delayed, or amelioreated by appropriate early recognition and therapy.

Physicians treating adults are not genetically oriented primarily because genetics entered medicine through pediatrics and obstetrics and focused on diseases of children. However, the needs are changing: children with genetic disorders previously incompatible with adult life are now not only surviving but are marrying and reproducing. Examples of such disorders are Wilson's disease and phenylketonuria. Still, those rare disorders cannot qualify as "everyday medicine." But good medical care today requires wider application of "old genetics" in adult medical practice.

Genetic disorders requiring case finding and appropriate intervention include hemochromatosis, familial polyposis coli, Wilson's disease, Marfan's disease, asymmetric septal hypertrophy, familial breast cancer, dysplastic nevus syndrome, neurofibromatosis, and familial hypercholesterolemia, to name only a few. These and literally hundreds of other genetic disorders in which intervention is beneficial bring genetics into "everyday medicine."

Most physicians focus on the individual patient seeking medical attention and regard case finding to be an onerous task. (Partly for that reason the work on case finding in veneral diseases has been turned

over to public health agencies.) Compounding the reluctance to obtain and study pedigrees is the perplexing ethical question of what to do with vital medical information acquired about a person who is not your own patient. For example, what is the responsibility of a physician to notify a family member at risk for a specific disease such as hemochromatosis if the patient does not wish to have the fact that he has the disorder disclosed to any one else.

The concept of genetic counseling may be remote and fuzzy to the adult practitioner. A concise definition is as follows:[1]

> Genetic counseling is a communication process which deals with the human problems associated with the occurrence, or the risk of occurrence, of a genetic disorder in a family. This process involves an attempt by one or more appropriately trained persons to help the individual or family (1) comprehend the medical facts including the diagnosis, the probable course of the disorder, and the available management; (2) appreciate the way heredity contributes to the disorder; (3) understand the options for dealing with the risk of recurrence; (4) choose the course of action which seems appropriate to them; and (5) make the best possible adjustment to the disorder and/or the risk of recurrence of this disorder.

Physicians who do not wish to obtain extensive pedigrees, contact family members at risk, and provide genetic counseling, should seek consultation with specialists in medical genetics for patients with genetic disorders. Such specialists are now certified by the American Board of Medical Genetics and are to be found in all three medical schools in the state of Florida. Our Division of Genetic Medicine in our Department of Medicine is the unit emphasizing diagnosis and treatment of adult genetic problems in our overall genetics program. We envision that this clinical discipline will grow in a logarithmic manner over the next several years and be fundamental to the practice of medicine. We believe and feel that our colleagues at the two other schools of Medicine agree that it is critical that the application of this new body of knowledge be available to all physicians in the care of their patients.

Karl H. Muench, M.D. and
Bernard J. Fogel, M.D., Dean
University of Miami
School of Medicine

1. Ad Hoc Committee on Genetic Counseling: Report to the American Society of Human Genetics. Am. J. Human Genetics 27:240-242, 1975.

WORTH REPEATING

Looking ahead: is generic medicine next?

Like a thorn stuck in our side the malpractice liability problem continues to give us pain, and we may not be relieved until the Federal Government and the people (consumers) achieve their goal to control us totally. At that time, the responsibility of health care will be dictated by the Government via the DRG's, and PRO's and PPO's and HMO's will potenitally incorporate all of us. Pessimistic outlook? I'll say!

In spite of our efforts to free ourselves from the tentacles of the lawyer-controlled legislature of this state and the squeezing vise-like pressures of the Government, we physicians are being funneled into the status of generics medicine. Is it possible? You bet it is!

The same people who are happy with generic drugs, generic eyeglasses, generic hearing aids, and generic foods, are the same people that we physicians treat as patients. The reason for the increasing shift to the above-mentioned generics is the cost of the product or services being higher than today's more aware consumer wants to pay. Although inflation in general has been controlled, the cost of health care services rose approximately 15 to 17 percent, compared to a 3.5 to 4.5 percent increment for all other consumer products in the last two years. Thus, the government encourages HMO's, PPO's and PRO's, and the development of the DRG system which will begin in all hospitals in the United States in October 1983. Soon after the DRG's will be invading and dictate the cost of private medicine as well.

If the people have left the friendly grocer for supermarket generic groceries, and if the people get their prescriptions filled in the chain store with generic drugs instead of using their friendly corner pharmacy, I believe that these same people eventually will consider going to the HMO's and industry will utilize the PPO's and HMO's for their health care because it will be cheaper; not better, just cheaper — and that seems to be the bottom line today. Many patients from both the private sector and industry are concluding that since their doctor is so impersonal and not so friendly, why not go to an impersonal and unfriendly doctor who is cheaper. Why pay the "extra" cost if the benefits are not going to be "extra." Most patients do not recognize dedicated from undedicated doctors or well trained from lesser trained doctors, one hospital from another hospital. When the equation of medical care is interpreted as

a doctor equals any doctor or any hospital equals a hospital, or an HMO equals a community hospital and its staff, then generic medical care will be here and will be marketed competitively for cheaper prices, but with increased volumes of patient encounters.

In this hypothesis, health care providers, HMO's and PPO's, and industrial corporations hiring their own physicians, will be employers of the physician. Physicians will be basically nondescript employees paid a salary with a bonus based on performance. This will produce physician indifference on both sides of the equation. If a physician indulges in too many "malpractices," he shall be relieved of his position, because his employer will no longer be able to afford him, just like a bank firing a teller who balances out short too frequently.

The above may be a bit exaggerated but it is possible. In order to avert (if we can), it behooves all of us to show more interest in our patients. Educate them, and communicate with them in a friendlier manner. We should attempt to keep our costs down as much as possible. We physicians should compete with each other and the HMO's and the PPO's for patients by offering them better service by being friendlier in the front office (on the phone and in the office) and in the examining room or consultation room. The patient's appreciation of this new, friendly, more understanding doctor will result in slowing down the exodus from our offices to the HMO's and the PPO programs. It also will reduce the incidence of malpractice claims because it will be more difficult for patients or even their lawyers to consider litigation against a friendlier, intelligent, understanding and compassionate doctor who is seen giving it all he can in trying to help the patient.

My friends, this is our only hope in really countering the malpractice liability problem and the development of a generic health care system.

Ernest G. Sayfie, M.D.
President, Broward County Medical Association

Reprinted with permission from *The Record* of the Broward County Medical Association, August 1983.

New developments in peer review

The role and objectives of peer review have evolved through a series of both voluntary and regulatory initiatives. One form of peer review began in 1919 with the American College of Surgeons' Hospital Standardization Program. This initiative was designed to maintain minimum hospital standards in the interest of achieving quality patient care. Today, in addition to its role in assessing patient care and utilization, peer review has become one of a series of mechanisms designed to control health-care costs. Recent regulations and draft requirements proposed for peer review under the Medicare Part A program have raised issues regarding the composition of Peer Review Organizations (PROs) and the scope of work to be performed by PROs.

In 1972, the government established Professional Standards Review Organizations (PSROs) as an amendment to the Social Security Act. Initially, the PSRO program was based on two concepts: that physicians are the most appropriate individuals to assess the quality of patient care, and that local peer review is the most viable means for ensuring appropriate use of federally financed health-care resources and facilities.

Ten years later, peer review provisions were enacted as part of P.L. 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA). The act repealed the PSRO system and established a new Utilization and Quality Control Peer Review Organization system. TEFRA reduced the number of peer review groups by broadening the geographic boundaries of Peer Review Organizations from local to statewide or regional. PROs are to be comprised of a "substantial" number of physicians. If, after 12 months, no physician PRO is available, TEFRA allows PRO contracts to be awarded to payer groups, such as insurers. PSROs were funded through federal grants; PRO contracts are to be awarded through competitive bidding. Only review of Medicare is required, although states may contract with PROs for Medicaid review, and PRO contracts with employers and insurers for private review are encouraged.

The Social Security Amendments of 1983 (P.L. 98-21), which included hospital prospective pricing provisions based on diagnosis-related groups (DRGs), further delineated conditions for PROs. The intent of PRO requirements in P.L. 98-21 was to inhibit potential abuses of the prospective pricing system, particularly in regard to increased admissions. P.L. 98-21 mandated that hospitals receiving payments under the prospective pricing system must contract with available PROs by October 1, 1984, in order to receive Medicare reimbursement. PROs are to review the validity of diagnostic information, completeness and adequacy of care provided, and appropriateness of admissions.

Proposed regulations by the Health Care Financing Administration (HCFA) published in August 1983 covered PRO area designations and eligible review organizations. Subsequently, HCFA published draft "scope of work" requirements for PROs. These implied that the goal of the PRO program is to reduce hospital admissions. Preadmission review also was implied in the draft scope of work, and comments were requested on how to identify cases for which preadmission review would be desirable.

The admission objectives set forth by the draft scope of work include a reduction of admissions for unnecessary [sic] invasive procedures and a reduction of unnecessary [sic] surgery or other invasive procedures with the potential for causing serious patient complications. The rubric "unnecessary surgery" is not defined nor quantified in the draft scope of work.

The draft scope of work set forth an "admissions factor" by which the effectiveness of PROs will be evaluated. Admission rates in a PRO area for given procedures will be compared with a national average. PROs will receive credit for admission rates below the national average. The credit will be used in calculating the cost benefit of the PRO contract.

The College has responded to the proposed regulations implementing PROs. In a letter to HCFA, Dr. Hanlon expressed the College's concerns with the proposed regulations on PRO area designations and definitions of eligible organizations. The overriding concern of the College is to assure that medical review is performed by peers in the specialty of the case under review.

Dr. Hanlon expressed the College's concerns regarding HCFA's draft scope of work requirements in a letter to HCFA's Office of Professional Standards Review Organizations. The College cautioned that the scope of work should not place a higher priority on reduced admissions to hospitals and cost containment than on assuring quality care.

Final regulations covering PRO area designations and eligible organizations and final scope of work requirements have yet to be published. It remains to be seen whether physician specialties will be adequately represented in PROs, and whether the goal of reduced admissions will affect quality-of-care assessment in the PRO program.

Nadine Chupack
Staff Assistant
Surgical Practice Department

Reprinted with permission from *The Bulletin of the American College of Surgeons*, Vol. 69, No. 2, February 1984.

CORRESPONDENCE

To the Editor: Last April I was fortunate to receive a copy of the FMA Auxiliary issue on Learning Disabilities. I sat up for two nights reading it from cover to cover. The past three years of frustration and concern finally fell into place. We have an LD son who is nine years old now. Until he was identified, we were confused and in an emotional upheaval from the various problems this disorder presented.

I realized that Tallahassee and the surrounding area had the capabilities to put together an awareness symposium on learning disabilities if there was enough interest to do so. I made several contacts in various disciplines and found the response to a symposium to be overwhelming. Our first brochures with pre-registration forms will be sent out at the end of February. The most exciting aspect of this effort is the cooperation of several disciplines — medical personnel, university professors, local school districts (teachers and administrators), state consultants, in addition to parental input. To date we have received contributions and manpower assistance from all the different areas.

I wanted to thank you personally for your excellent editorial. The April Auxiliary issue was truly the impetus for this our first LD Symposium. I would like to extend a personal invitation to you to join us here in Tallahassee on May 19, 1984 (Saturday). The location is the Center for Professional Development on the FSU campus. Professionals in all disciplines will receive credit for their attendance.

Again, my sincere thanks for all your efforts.

Betty Ashler
Tallahassee

Book Review Editor — **F. Norman Vickers, M.D.**

Living with herpes

By Deborah P. Langston, 198 Pages. Doubleday & Company, Inc., Garden City, NY, 1983.

This book is written by a research-ophthalmologist for a lay audience in order to "dispel fear" and help them cope "through knowledge of which herpes virus we have and what behavioral patterns we can expect from them." Selections from the extensive literature on HSV infections, are paraphrased and summarized with a refreshing lack of journalistic hyperbole. The coverage is moderately complete and the lay reader will not notice the omission of Aurelian's pioneering work on anitbody characterization and Jarratt's indispensable studies of therapeutics.

The major portion of the book deals with the many facets of genital herpes. There is an interesting and fairly complete discussion of the history of herpes, and the section on psychologic implications is well done. In addition to common sense descriptions of the various psychotherapeutic approaches available, the book offers practical suggestions on how to choose a therapist. Short discussions of puerperal hygiene, cancer, ophthalmic, skin, oronasal, and neurologic involvement, herpes zoster, and CMV infection are also included. Some of these sections are only seven paragraphs in length and yet are listed as full chapters in the Table of Contents. Such obvious literary "padding" is neither necessary nor appropriate.

But before recommending this book to your patients, be aware of a disappointing lack of emphasis on the concepts of self-control and personal responsibility in the epidemiology of the disease. Some patients may be misled by the reference to a *TIME* magazine article in which a woman contracted herpes "because her doctor misinformed her about the infectivity of the disease." In fact, herpes is contracted by intimate contact with an infecting agent, which is often the result of a free choice, informed or otherwise. Such attempts to transfer responsibility from the individual to the medical profession are themselves irresponsible. Equally irritating, especially in view of the known propensity of the virus to "silent shedding," is the advice given regarding prevention: "Sex isolation may induce reactivation. . .so. . . maintain as normal a sex life as possible. . .but inspect your partner's genitalia for sores." Nowhere does the author squarely address the promiscuous nature of the behavior responsible for the epidemic spread of the disease.

One wonders if similar media attention will ever be given to the much more prevalent, more oncogenic and potentially more dangerous viral venereal disease, that of Human Papova Virus (HPV) infection which the author dismisses as a "perfectly benign problem." But, if one can over look these shortcomings, Dr. Langston's book presents the story of herpes with acceptable scientific accuracy in a readable manner suitable for the lay public.

Eduard G. Friedrich Jr., M.D.
Gainesville

● Dr. Friedrich is Professor and Chairman of the Dept. of Obstetrics and Gynecology, and is Director of the Vulvar Disease Referral Clinic at the University of Florida College of Medicine. He is also author of the book *Vulvar Disease*, Second Edition, W.B. Saunders Co., 1983.

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussions of medical history and ethics; and articles dealing with socioeconomic, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to Daniel B. Nunn, M.D., Editor of *The Journal*, Florida Medical Association, Post Office Box 2411, Jacksonville, Florida 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal*.

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

Abstract. All scientific manuscripts should include a 150 word, maximum length, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request".

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double-spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication".

When received, the senior author will be sent an acknowledgement of receipt and a copyright agreement which must be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates. PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis. Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72) and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request

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Auxiliary Liaison Editor — **Mrs. L. G. (Mae) White**

The Doctors' Day Blood Drive — a gift of life

Central Branch of Pinellas County Medical Auxiliary introduced the Doctors' Day Blood Drive in 1982. The day was successful beyond their greatest expectations. Eight hundred fifty-one pints of blood were donated in honor of the physicians of the community. It was the largest single day blood drive in the history of the county. What better way to honor doctors than to give blood — the gift of life. Many people do not worry about the availability of blood until someone they love needs it. Doctors have this worry every day for their patients. A generous response from the community indicates a willingness for personal involvement and cooperation, and is a great way to recognize doctors.

The FMA Auxiliary and the Southern Medical Auxiliary both bestowed their awards for best observance of Doctors' Day that year to Pinellas County. The idea was shared through the FMA Auxiliary publication, *The Quarterly* and the AMA Auxiliary publication, *Facets*.

Encouraged by the results, the Auxiliary gathered forces and implemented a 1983 blood drive which resulted in the donation of 1,065 pints of blood. Donors received a T-shirt emblazoned with "I Shared a Pint With My Doctor", "Once Is Not Enough", and "Doctors' Day Blood Drive 1983".

Mrs. Charles Markham, current Central Branch Chairman, Pinellas County Auxiliary, is most enthusiastic that the 1984 Doctors' Day Blood Drive for the gift of life will net an even greater number of pints of blood. She relates that Doctors' Day offers a great opportunity to remind our community that having blood available can mean the difference between living and dying. The Central Branch is being joined by the North Branch as they prepare for the 1984 blood drive. Their goal is to be able to send a card to all doctors in the community which reads, "On your behalf, 1,300 pints of blood were donated for the patients of the area."

Traditionally, the red carnation is the symbol of Doctors' Day. It was chosen because of its analogy to medical science. The color red symbolizes courage. The spicey scent denotes honorary distinction. From the juice of its petals a wine has been made "that did comfort the heart of man". The date, March 30, was chosen to commemorate the first use of ether as an anasthetic in surgery by Dr. Crawford W. Long in 1842. This discovery became one of the greatest medical discoveries of all times because it relieved mankind of pain and paved the way to even greater advances in medicine and surgery.

The red carnation is still being used in Doctors' Day observances throughout 16 southern states and the District of Columbia; however, times have changed since the Southern Medical Auxiliary first adopted Doctors' Day in 1935. Today auxiliaries are finding new ways of recognizing doctors. Emphasis is being placed on the public relations value of stressing contributions made by physicians to the health of the community on Doctors' Day. Community service projects reveal the dedication, unselfishness, and daily devotion of the medical profession.

Perhaps Pinellas County has laid the groundwork for still another tradition for Doctors' Day. If the Doctors' Day Blood Drive were to spread statewide, or even nationwide, just think of the gratitude of the blood banks in having enough blood to satisfy the demands made upon them.

The annual observance of Doctors' Day each March 30th can help create a public awareness of the important roles physicians play in community endeavors. A positive public approach as used by the Pinellas County Auxiliary is a potent force in aiding public understanding of the physician who quietly goes about his everyday work caring for the sick and injured, helping in the prevention of disease, and coping with the complexity and multiplicity of governmental regulations and bureaucratic paperwork.

The red carnation is a nice gesture, but how much more meaningful is the Doctors' Day Blood Drive as a celebration of Doctors' Day for 1984.

Mrs. Walter (Isabella) Laude, Councilor
Southern Medical Association Auxiliary
Babson Park

AMA-ERF fund raiser

You may contribute to the American Medical Association Education and Research Foundation by purchasing Medical Motif T-shirts.

Adult Sizes $10.00 S(34-36) M(38-40) L(42-44) XL(46-48)
Youth Sizes $ 8.00 S(6-8) M(10-12) L(14-16)

You may also contribute by purchasing the following:
Nautilus Tote Bag, Tan only, $10.00
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Jacksonville, FL 32217

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 "Have you hugged your doctor today?" 1	 "PLASTIC SURGEONS MAKE MOUNTAINS OUT OF MOLEHILLS." 2	"Urologists are people plumbers." 3	"I'M MAD ABOUT MY PSYCHIATRIST." 4	"ENT'S ARE INTERESTED IN CULTURE." 5	"Plastic surgeons give me a lift."
"OPTHALMOLOGISTS MAKE YOU SEE THE LIGHT" 7	"PLASTIC SURGEONS MAKE MOUNTAINS OUT OF MOLEHILLS." 8	"Obstetricians deliver the goods." 9	"Surgeons are clever cutups." 10	"Trust your heart to a CARDIOLOGIST." 11	"BABY DOCTORS NEED A CHANGE" 1
"Tell your PROCTOLOGIST to sit on it." 13	"DERMOTOLOGISTS make rash decisions." 14	"NEUROLOGISTS get on my nerves." 15	"PATHOLOGISTS are dead serious." 16	"Internists know you from the inside out." 17	"SLEEP BETTER WITH AN ANESTHESIOLOGIST" 1
"Have you hugged your doctor today?" 19	"ORTHOPEDISTS CAN MAKE YOU OR BREAK YOU." 20	"Family physicians have more patience." 21	"Radiologists see right through you." 22	 Tote 23	 Apron

FMF IMPAIRED PHYSICIANS COMMITTEE NEWSLETTER

Published by the Committee on Impaired Physicians / Florida Medical Foundation / P. O. Box 2411 / Jacksonville, Florida 32203

April 1984 | "Doctors Helping Doctors" | Vol. 1 — No. 2

HRS Official Praises FMA Drug Abuse Role

The Florida Medical Association was credited at a multi-state regional meeting last month for maintaining an active program to curb drug abuse.

FMA has maintained a drug abuse committee in some form for at least 14 years, Frank D. Nelson of Tallahassee told the Southeastern Conference on Prescription Drug Abuse. He also praised FMA for its good working relationships with such governmental agencies as the Florida Department of Health and Rehabilitative Services.

Mr. Nelson, Director of the HRS Drug Abuse Program, was one of four panelists who reported on "The Florida Experience," during the final session of the three-day program at Charleston, S.C., on March 16. Florida was one of the first five states to participate in field tests for the AMA-sponsored Prescription Abuse Data Synthesis (PADS) Project, and Mr. Nelson and other speakers addressed the State's participation and progress to date.

Speakers stressed that the battle against drug abuse can be won only if all the interested parties from both the government and private sectors will sit down at the same table, lay their differences aside and construct positive approaches that all can live with. Such has been the case in Florida, where the PADS project has brought to one table the FMA and other professional groups, plus several federal and state agencies.

More than 100 representatives from the states of Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, and Tennessee attended the conference, which was sponsored by the AMA, the South Carolina Medical Association, the federal Drug Enforcement Administration and other groups.

FMA was represented by Joseph H. Deatsch, M.D., of Jacksonville, a member of the FMA Committee on Substance Abuse, and Mr. Edward D. Hagan, of Jacksonville, Director of the FMA Department of Medical Services.

Section on Chemical Dependency Planned for FMA Annual Meeting

For the fourth consecutive year, the Committee on Impaired Physicians will sponsor a Section on Chemical Dependency during the 110th Annual Meeting of the Florida Medical Association.

Dolores A. Morgan, M.D., Medical Director of the IPP and Program Chairman for the Section, said the three-hour program would be conducted on Thursday afternoon, May 3, beginning at 1:30 p.m., at the Palace Hotel in Lake Buena Vista. All physicians and guests registered for the Annual Meeting are cordially invited to attend.

"The Disease Concept of Alcoholism" is the title of the first talk, which will be presented by David Ohlms, M.D., Medical Director of St. Anthony Medical Centers Highlands Center, St. Louis, Missouri. Charles V. Wetli, M.D., Deputy Chief Medical Examiner of Dade County, will speak on "Cocaine: The Craze of the 1980s".

The program has been approved for three hours of AAFP Prescribed, AMA Category I, and FMA Mandatory Credit.

The Opposite Effect

We drank for joy and became miserable.

We drank for sociability and became argumentative.

We drank for sophistication and became obnoxious.

We drank for friendship and made enemies.

We drank for sleep and awakened exhausted.

We drank to feel exhilaration and ended up depressed.

We drank for "medicinal purposes" and acquired health problems.

We drank to get calmed down and ended up with the shakes.

We drank for confidence and became afraid.

We drank to make conversation flow more easily and the words came out slurred and incoherent.

We drank to diminish our problems and saw them multiply.

We drank to feel heavenly and ended up feeling like hell.

We drank to cope with life and invited death.

IP Hotline

Do you know a physician in trouble with alcohol or drugs? Do him a favor and call the Florida Medical Foundation Hotline:

1-305-667-8717

or call your county medical society Impaired Physicians Committee.

Program is Presented For UF Med Students

Approximately 50 University of Florida medical students, house staff and faculty attended a February 28 program on physician impairment sponsored by the Committee on Impaired Physicians, the College of Medicine and the Department of Professional Regulation.

Speakers included: Lynn Hankes, M.D., Medical Director of the Alcoholism Unit at Lakeland Regional Medical Center; Jules Trop, M.D., a Miami Addictionologist; Mr. Joe Lawrence, an attorney for the Department of Professional Regulation; and Guy T. Selander, M.D., Chairman of the FMF Committee on Impaired Physicians.

150 Physicians and Others Seen In First 37 Months of IP Program

One hundred fifty physicians and others have been seen during the first 37 months of the FMF Impaired Physicians Program, according to Dolores A. Morgan, M.D., Medical Director.

The total number included 128 doctors of medicine, 12 dentists, two osteopaths, five pharmacists and three veterinarians, Dr. Morgan said in her annual statistical report.

Most of the M.D.s (71) were treated for drug addiction, while 52 were diagnosed as alcoholics and the remaining five suffered from psychiatric disorders.

Thirty-four professionals who have gone through the program — 30 M.D.s, one dentist, one veterinarian and two pharmacists — have been free of chemicals for two years or more.

During the most recent one-year reporting period — February 1983 thru January 1984 — 46 professionals, including 36 M.D.s were seen, the report said.

The Committee on Impaired Physicians maintains a loan fund to help needy impaired physicians to pay for their treatment.

The fund was made possible by a number of tax deductible contributions to the Florida Medical Foundation from physicians, Auxilians and others.

Several contributions of $300 or more have been made, according to Chairman Guy T. Selander, M.D. In return for donations of $300 or more, the Foundation will give the donor an unframed print of the well-known painting "Caduceus," a work of the late Lee Adams of Jacksonville.

"But we welcome contributions of any size," Dr. Selander said. He said checks should be made payable to "Florida Medical Foundation" and marked "Impaired Physician Loan Fund."

Eligible members of the FMA, upon recommendation of their county medical societies, can apply for loans of up to $2,500 repayable at 12% interest, to help finance treatment for chemical dependency.

These loans are for treatment only," Dr. Selander stressed. "We cannot lend money for household expenses or other reasons."

FMA Contributes Intervention Plan For State Drug Diversion Program

The Florida Prescription Abuse Data Synthesis (PADS) project, a cooperative effort to identify sources of drug diversion, is nearing the operational phase.

Representatives of two FMA Committees — Substance Abuse and Impaired Physicians — have been participating in the planning along with the Drug Enforcement Administration, Florida Department of Professional Regulation, Florida Department of Health and Rehabilitative Services, Florida Pharmacy Association, and other groups.

The program is focusing on four types of doctors and other medical professionals involved in drug diversion:

- — Dishonest or script doctors and medical professionals.
- — Disabled or impaired.
- — Duped (those who unwittingly acquiesce to patient's pleas for drugs).
- — Dated (those who have not kept up with pharmacology and drug therapy).

The PADS Policy Group adopted an identification and intervention protocol suggested by the FMA. Disabled professionals would be referred to their state professional organization with M.D.s being referred to the Impaired Physicians Program.

The services of the FMF Impaired Physicians Program are available to the other professional organizations until they "individually or collectively establish their own programs."

Doctors or other professionals determined to be "duped" or "dated" will be referred to their professional societies for continuing education.

IP Committee Nears Fourth Anniversary

Guy T. Selander, M.D., of Jacksonville, is in his fourth year as Chairman of the FMF Committee on Impaired Physicians.

Mrs. B. David (Edie) Epstein of Key Biscayne, a Past President of the AMA Auxiliary, serves on the Committee as an appointee of the FMA-A.

Dr. Selander said that since the symptoms of chemical addiction usually become apparent in the home before they are noticed elsewhere, the role of the Auxiliary in the Impaired Physicians Program is a vital one.

Other members of the Committee are: John M. Butcher, M.D., of Sarasota, a family physician; John F. Mason Jr., M.D., of Panama City, a Past President of the Florida Psychiatric Society; Arvey I. Rogers, M.D., of Miami, a gastroenterologist; and Hector Mendez, M.D., of Orlando, a family physician.

Dolores A. Morgan, M.D., of Miami, Medical Director of the IPP, and George S. Palmer, M.D., of Tallahassee, Medical Consultant to the Department of Professional Regulation, are ex officio members of the Committee.

Medical Director Hunt Likely to End in May

The FMF Committee on Impaired Physicians is evaluating applications for the position of Medical Director of the Impaired Physicians Program and expects to make a recommendation as to an appointee by the time of the FMA Aunnual Meeting in May.

A national search was conducted through medical journals and communications with other state medical associations. March 15 was the deadline for applications.

The Committee hopes to have a full-time medical director on board by late summer to succeed Dolores A. Morgan, M.D., of Miami. Dr. Morgan, who has held the post on a part-time and temporary basis for three and a half years, asked to be relieved of her duties as soon as a suitable successor could be found.

Mrs. Epstein Speaks At Hialeah Workshop

Mrs. B. David (Edie) Epstein of Key Biscayne, a member of the FMF Committee on Impaired Physicians, served as moderator of the Annual Workshop on the Medical Marriage in Hialeah on February 26.

PRESIDENT'S PAGE

Medicine united!



Members of the Florida Medical Association across Florida are united in their efforts to contain costs of medical care and to educate the public about the influence of the problems of medical malpractice on cost access and quality of health care. The Board of Governors of the Florida Medical Association at its meeting on March 9 and 10, 1984, and many other component county medical societies have voted to support the recommendation of the American Medical Association for a voluntary freeze on physicians' fees. This positive action is taken to demonstrate to the public that we, the physicians, are interested in the cost of health care and will do our part in helping to control costs in spite of the costs of medical malpractice.

The visits I have made to the various county medical societies have been received with warmth and overwhelming support of the recommendations of the Florida Medical Association for resolution of the professional liability problem. The bills incorporating the proposed recommendations for tort reform have been filed in the Florida Senate and House of Representatives. The constitutional revision proposal for the November ballot have been prepared and will be distributed shortly to physicians' offices, the Florida Medical Association Auxiliary and citizens across the state.

The special dues assessment is being received in an overwhelming response. On April 5, 1984, over 3,200 active members have paid their special assessment, and 296 members have made voluntary contributions. This fantastic response is over the three week period of time since the dues notices were mailed. In addition, one hospital medical staff in south Florida has made a $2,000 contribution to help with the constitutional revision initiative. All different physician groups in Florida are also united and have pledged their support in this common cause to resolve the terrible spectre influencing medical practice.

But in our zeal and quest for victory, we must also remain united in remembering our service to the public. We must continue to render the best medical care possible in a humane and concerned way. Our patients are our cast, audience and critics in the theater of health care. Let us all work together to receive their applause, appreciation and support.

J Lee Lockwood

AMA Hospital Medical Staff Members:

Strengthen Your Role in Decision Making . . . Influence AMA Policy!



The AMA Hospital Medical Staff Section Third Assembly Meeting June 14-18, 1984 / Chicago, Illinois

As a hospital medical staff representative, you should plan now to attend this four-day AMA Hospital Medical Staff Section Assembly Meeting. You will have an opportunity to contribute to the decision-making process and participate in developing policy that will address the issues and concerns of physicians on hospital staffs.

The AMA Hospital Medical Staff Section provides representatives from hospital medical staffs with a forum to discuss common problems and changes in physician-hospital relations, and a direct voice in policies being considered by the American Medical Association.

Group sessions are conducted on various topics of interest to hospital and medical staff members. Presentations include such topics as: credentialing, hospital contractual relations, and overall relationships between physicians and hospitals.

Here's your opportunity to effect change. For information contact the AMA Department of Hospital Medical Staff Services at (312) 645-4747 or (312) 645-4753

HMSS

AMA
AMERICAN MEDICAL ASSOCIATION

FMA's fight against alcohol and drug abuse

The Florida Medical Association has assumed a leadership role in the fight against a national epidemic of alcohol and drug abuse. Noteworthy examples of this leadership are our program for impaired physicians and the AMA's PADS (Prescription Abuse Data Synthesis) project which was suggested by and continues to receive active support from the FMA. We may be proud of these excellent projects, but cannot rest on our laurels. The fight has just begun. In the overall war on drugs we have barely touched the tip of a huge iceberg.

A recent study by the National Institute of Mental Health estimates that 13% of American adults are problem drinkers or alcoholics and 7-8% are in trouble with other drugs.[1] A significant number of our patients present to us with complaints secondary to alcohol or other drug use. As many as 50% of emergency room patients and 25% of hospital bed occupants may have problems related to the use psychoactive substances but most often the relationship is unrecognized. Highway carnage related to alcohol abuse is a major national concern but may be less of a public health problem than the carnage that occurs in families of the user. The millions of American children who grow up in homes with alcoholic or drug dependent parents are at increased risk of child abuse, incest, and co-dependency, a pattern of psychopathology which arises as a self protective mechanism of adaptation.

We live in a society where alcohol use is expected. Easy access and commercial messages encourage the use of drugs, licit and otherwise. Susceptibility to drug abuse varies with developmental age, environmental stress, peer group, family patterns of use, religious beliefs, and genetic makeup. At highest risk are our youth who are users themselves in unprecedented numbers. These developmentally immature young people aware of widespread adult use and media glamourization of use see alcohol and drug involvement as rites of passage and begin to experiment with substances that may lead to their demise or to progressive involvement. For many achievement of full adult potential will be continued use. Society's future may well hang in the balance.

Too often in focusing our thoughts on the such organic properties of drugs as their effects on the lungs, liver, and heart we overlook their most important properties. Psychoactive drugs are dangerous mainly because they affect the brain and cause alteration of sensory perception and response. Drugs used for social relaxation, relief of pain and anxiety, or escape from boredom and loneliness may cause euphoria and this euphoria may become so powerfully reinforcing that the user is seduced into continued and/or escalated use. Death or disability may arise from accidents of acute intoxication. Repeated use may lead to the emotionally and socially crippling disease called chemical dependency.

Physicians, themselves, are not immune. Repeated studies have shown rates of alcohol abuse among doctors that are comparable to those of the general population and our rates of other drug abuse are higher. The chemically dependent physician frequently escapes detection because of high intelligence and excellent education and because he/she does not fit the classical conception of the skid row drunk or addict. Alcoholism characteristically affects all areas of a person's life before work performance suffers and most chemically dependent physicians continue to practice and are not themselves consciously aware of their chemical dependency. Medical peers may not suspect that they are having problems, but their families are usually in great distress. Coping mechanisms may keep these families well enough to present normal appearances.

We physicians must increase our efforts to overcome this public health menace and become the leaders in a societal fight to prevent and treat drug

abuse. Those of us who have been ambivalent or silent about the issues involved need to become more aware of prevalence, etiology, diagnostic methods and effective techniques for prevention, intervention and treatment. Those who claim that these are primarily moral or social issues should re-examine their positions and see that death and disability are clearly responsibilities of health care providers. Florida physicians have an opportunity and a mandate to lend the fight against alcohol and other drug abuse. This Special Issue of *The Journal* is a sign of our concern and can be an educational and symbolic vehicle around which we rally.

Donald Ian Macdonald, M.D.
Clearwater

Continuing medical education

Of necessity the Florida Medical Association has recently devoted much time and many resources in an attempt to control sociological forces impacting upon the private practice of medicine. Major goals have been to preserve the private patient/personal physician relationship, to prevent control of physicians by prejudiced and biased organizations, and to sponsor and support mechanisms for cost containment.

Members of the Florida Medical Association should not forget, however, that education is the basis for our success. Our valuable educational experiences cannot be "legislated" away from us. The impact of education can only be lost through neglect, i.e. neglect to take advantage of continuing medical education opportunities. Fortunately, the Florida Medical Association continues its leadership role in the field of continuing medical education in Florida.

In 1971, the American Medical Association awarded the Florida Medical Association Committee on Continuing Medical Education the privilege of approving institutions to offer Category I program credit. (This Committee has since been renamed the Committee on Medical Education.) Since that time, 41 hospitals and organizations in Florida have been approved to offer AMA Category I programs. In 1983, a total of 516 Category I credit hours were approved and 38 programs were co-sponsored by the Florida Medical Foundation Committee on Medical Education.

The Florida Medical Association continues to offer an outstanding scientific assembly as part of its annual meeting each May. This year is no exception and an exciting program is being presented with no registration fee required. A total of 20 hours of AMA Category I credit will be available to participants attending high-quality educational programs offered through 33 scientific sections sponsored by FMA recognized specialty societies. In addition, 23 scientific and educational exhibits will be on display including the popular Wyeth Autotutors. The Pfizer Dialogue series will be offered on Thursday afternoon to include topics on "Somatic Manifestations of Depression," "Mixed Angina," and "Alternative Health Care Systems." Certainly the most exciting section of the program will be a Florida Medical Association sponsored symposium presented from 9:00 a.m. to 10:30 a.m., Friday, May 4th, entitled, "The Health of the Public." Speakers will include two men who are at the center of world and United States health, the two most knowledgeable men in their field in the world: Edward N. Brandt, M.D., Assistant Secretary of Health and Human Services, and James Mason, M.D., Director of the Center of Disease Control. In addition, J. Lee Dockery, M.D., will serve on this important and timely program. It is indeed a rare privilege to have the opportunity to hear these three outstanding physicians on the same program.

The Journal of the Florida Medical Association continues its contribution to medical education. Its leadership in the field of scientific medical literature has been recognized by the coveted Sandoz Award as the best state medical journal in the United States in 1983.

Admittedly, there is no method to demonstrate improved patient care as a direct result of mandatory continuing medical education. Sociological forces are demanding accountability, however, and there is no doubt that continuing medical education will remain a necessity for survival. Mandatory reporting of continuing medical education credit is somewhat demeaning to the physician and the current mechanism employed by the Florida Medical Association is outdated and cumbersome. The Committee on Medical Education is in the process of studying new computer-based systems of reporting and should formulate a recommendation for the Board of Governors in the near future. A simplified system of reporting should prove to be much more palatable and should result in increased compliance.

When all is said and done, physicians must recognize that continuing medical education is a way of life. I hope to see each of you in Lake Buena Vista, May 2-6, 1984.

Henry M. Yonge, M.D.
Pensacola

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Special Issue on Substance Abuse

Co-sponsored by FMA Committee on Substance Abuse and FMA Auxiliary

Introduction by John S. Flint, M.D.



Abuse of drugs is rampant in our society on a scale so vast as to be hard to comprehend. It affects all ages, and touches everyone's life in some way.

Most physicians are poorly educated regarding all aspects of substance abuse, and do not even realize how naive they are in this regard. Most do not recognize substance abuse in their patients, and are unprepared to cope with the problem effectively when they do. Because of our ignorance, we even contribute to the supply of illegally marketed and misused drugs through our prescriptions. In his article, Dr. Dale K. Lindberg tells of some of the schemes that addicts use to deceive physicians and obtain prescriptions for their drugs.

Recognizing that it is impossible to cover the whole field in one issue of *The Journal*, we have settled for a spectrum of articles mostly by authors from within our state. The only exception is an article by Dr. Joseph H. Skom who describes the AMA's actions regarding prescription drug abuse. It is relevant, since Florida is one of five states participating in the PADS (Prescription Abuse Data Synthesis) project.

Since experimentation with drugs often begins in adolescents, or even preteens, the article by Dr. Kay Hanley on guidance to be given at the office visit should prove useful to all who treat adolescents. The importance of early intervention in young drug abusers is underscored by Dr. Charles E. Koch and colleagues in describing their program for the adolescent drug abusers.

Dr. Dolores Morgan, well known for her pioneer work with Florida's Impaired Physicians' Program, has joined with her colleagues in presenting a little known aspect of drug abuse, i.e., its close association with a variety of sexual problems.

Lack of space has prevented us from discussing most specific drugs, even those of common abuse such as alcohol and marijuana. Although these are major drugs of concern, we elected to highlight cocaine instead. Because of cocaine's immense and growing popularity, Dr. Lynn Hankes' concise yet thorough review of this drug is timely and should be of use to all practitioners.

We are all aware to some degree of prescription misuse by patients, especially elderly ones, but many of us may be surprised to find how extensive a problem this is as described by Landress and Morck. Lastly, Dr. Melvin Stone, from his extensive experience with treating addicts, reflects on addiction as man's inept way of coping with the stresses of our society.

Our goal for this Special Issue is to increase the physician's awareness of the importance of drug abuse and its relevance to the practice of medicine. It has been a special pleasure to share sponsorship of this issue with the FMA Auxiliary, whose contributions to this issue have done much to help complete the list of problems and issues we hoped to cover.

John S. Flint, M.D.
Co-editor
St. Petersburg

Introduction by Mrs. Mae (L.G.) White



As evidenced by the existence of Substance Abuse Committees in both organizations, the FMA and the FMA Auxiliary each have an active interest in the rampant, almost epidemic, incidence of substance abuse existing in our society today.

Too many people of all ages are smoking, drinking alcohol to excess, popping pills, injecting drugs and inhaling substances to the extent that they are harming themselves and others, for the medical profession to ignore.

Physicians have accomplished miracles in eradicating measles, mumps, TB and polio, but progress in eliminating substance abuse has been painfully slow. Traditional medical treatment alone is not enough. This time the battle involves the community, government, industry, the media, the institutions of education and all the basic structures of our society. This special issue of *The Journal*, which is co-sponsored by the Auxiliary, addresses this important and timely issue. The topic is of such proportions that it would be impossible to cover all of its aspects even superficially, let alone in depth.

These are the basic questions: What substances are being abused and how widespread is the abuse? Is this abuse on the increase or decrease and among what segments of our population? Why, and what is the impact on our society? What is currently being done to decrease or prevent this? What can be done in the future? What special role can the medical profession play? We tried to solicit articles which attempt to answer some of these basic questions.

Articles solicited by the FMA Substance Abuse Committee are authored by physicians and deal mostly with the scientific and medical aspects of substance abuse.

Articles solicited by the Auxiliary are written by persons from other disciplines and deal more with the roles played by education, legislation, industry and community organizations.

Each author makes a unique contribution and we hope that the potpourri falls into place and helps our readers to have a clearer, more comprehensive and current picture of the nature of the problem and their special roles in relation to it as physicians.

It has been a pleasure to work with the authors of the articles; the co-editor, Dr. John Flint; the Auxiliary President, Priscilla Gerber; and *The Journal* staff on this Special Issue.

Mrs. Mae (L.G.) White
Co-editor
Fort Lauderdale

Florida Medical Association
Committee on Substance Abuse
1983-1984

Donald I. Macdonald, M.D., Chairman
Edward B. Jaffe, M.D.
Donn L. Smith, M.D.
Jorge R. Pena, M.D.
Joseph H. Deatsch, M.D.

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The drug abuse epidemic



The use of drugs by young people is one of our country's greatest problems. It is a plague that is ruining the minds and bodies of our children. If we don't do something right now about drug abuse, we are in danger of losing an entire generation of our children.

Never in my life have I felt as compelled to do something about an issue as I feel about this one. My primary purpose in this battle against drugs is to draw attention to the problem, to make people aware and get them involved. That's why I decided to travel around the country to visit as many drug rehabilitation centers and prevention programs as possible and talk to as many young people as possible.

And that's why I have been working through the medium of television to try and reach the widest audience possible. One of the most innovative drug awareness projects with which I have been involved is *The Chemical People*. This two-part television program, broadcast on PBS in November, brought together thousands of Americans in communities all across the country in an effort to confront and deal with the problem of drug and alcohol abuse. Nearly 11,000 town meetings were held where people joined to watch the programs together. With continued community support, those town meetings will evolve into permanent task forces aimed at helping our children be drug-free.

The things I have seen and heard in the last few years are enough to make the strongest hearts break. I have traveled thousands of miles talking with kids, listening to them, asking them questions and learning a good deal. They all seemed so anxious to tell me how they got into drugs, who turned them on, what their lives had been like. They talked about drugs I'd never even heard of. They had had experiences that were hair-raising. I heard how drugs had killed their hope, their promise, their spirit and their love. And how drugs had turned them against their friends and families and toward a world of pain and isolation.

But when they finished, the result was always the same — that they wished they had never gotten involved. And the one thing they wanted more than anything else was to re-establish their relationship with their families and have a normal, happy life again.

The victims are getting younger all the time. Not too long ago, I visited a third grade class in Atlanta and sat in on a drug prevention program. It struck me as odd to see little boys in Cub Scout uniforms and little girls in jumpers learning about drugs that even adults can't handle. The scene was, at the same time, both terrifying and encouraging. Terrifying in that drugs are such a problem even third graders must be prepared to deal with them. And encouraging in that we finally are fighting back to prevent drugs from taking any more of our children.

The numbers — as well as the thousands of letters I receive from all over the country — tell that drug abuse has reached epidemic proportions. Right now, it is like one of those dread diseases for which there is no cure. It crosses all boundaries. Rich and poor are not immune. Neither are the educated or non-educated, black or white. Drugs have invaded the cities all across America as well as the rural areas.

Our top priority is prevention. It is safer and more effective to thwart drug abuse before it begins, than to wait after the fact and hope the young person will come in for treatment — an emergency procedure in which we sometimes lose the patient. We must begin to educate parents, as well as their children, to

the dangers of drugs. This is where the knowledge and expertise of the professionals is so important.

I am very pleased to know the Florida Medical Association and Auxiliary have chosen to focus on substance abuse prevention throughout the state of Florida. You can do so much to educate not only parents and children, but teachers, civic groups and local leaders. Everyone needs to get involved in the fight against drug and alcohol abuse if we are to continue to make progress. Your expert advice can guide us toward a drug-free existence for our youth.

Please accept my heartfelt thanks for your commitment. My thoughts and prayers are with you. I am sure that by working together we can make a difference.

Mrs. Nancy Reagan
Washington, D.C.

The adolescent visit: an opportunity for anticipatory guidance

Kay Knight Hanley, M.D.

ABSTRACT: Adolescents seek medical care both for routine physical examinations and with intercurrent illnesses. The physician caring for children is recognized by parents as a source of advice on a variety of topics, including educational guidance, drug and alcohol use, issues of parent power, smoking, exercise, sex, and sexuality. The interests of the adolescent can best be served by the physician who is genuinely fond of adolescents, listens keenly, and is objective and non-judgemental in his approach. Counseling teenagers on a variety of issues is appropriate, rewarding, challenging, and well worth the time required.

The Author
KAY KNIGHT HANLEY, M.D.
Dr. Hanley is a general pediatrician in private practice, Clearwater.

Primary care physicians are in a strategic position to provide counseling to adolescents and their families that integrates physical health care with mental health. Increasingly, families expect their physician to provide advice in areas other than those concerned strictly with the physical health of their children.[1, 2] Residency training programs in the past have placed little emphasis on the psychosocial issues of adolescence, therefore, many practicing clinicians feel unsure when they try to assume medical responsibility in the dual role of provider of health care and of mental health.[3]

The Report of the Task Force on Pediatric Education in 1978, sponsored by the American Academy of Pediatrics, explored new directions and responsibilities of those involved with health care of our youth and emphasized the advisability of providing anticipatory guidance at all ages including adolescence.[4]

Anticipatory guidance has long been recognized as a proper function of physicians not only in areas of health advice but also in providing information to parents about the developmental stage of their children, as well as the emotional and psychosocial changes that accompany each stage.[5, 6] Families perceive a need for such information and many families while in for an acute illness express concern about behaviorial issues not related to the situation which prompted the visit.[7]

Results of a recent survey by Hoekelman et al[2] indicated that 15.6% of visits to pediatricians were by teenagers and of this group 18.3% of the 10-14 year old patients and 22.2% of those 15-19 were seen for well patient care. Certainly these visits provide an ideal opportunity to offer counseling related to health by an involved caring physician who often knows the patient well. In addition, the physician provides another influential adult model to the adolescent.[8] On

many topics related to bodily changes and sexual maturity the adolescent may talk more openly with the physician than his parents about his concerns and questions.

The onset of the physical changes of puberty heralds appearance of the associated psychosocial growth and development of the individual known as adolescence. Adolescence is frequently divided into three phases, early, mid, and late, depending on the psychosocial ability and physical development of the individual. Knowledge of these developmental changes is essential to the adolescent's physician.

Felice and Friedman, outstanding advocates of adolescent medical care, succinctly state these stages and growth tasks of adolescents and provide a foundation for understanding these stages.[9]

Late adolescence is the stage during which most sexual exploration occurs and statistics related to the results of this are impressive.[10-12] Of almost 1 million teenage young women who become pregnant each year, nearly 600,000 infants are delivered and another 400,000 pregnancies are aborted. The emphasis is on results of the pregnancy itself while the concomitant fact that at least 1 million adolescent males become biologic fathers should receive more emphasis.

Young drivers were involved in one third of the fatal car crashes in 1982[13] and in 1981 28% of the teenage drivers involved in fatal motor vehicle accidents had been drinking alcoholic beverages.[14] Drug use is prevalent in adolescents and about 50% of high school seniors have reported experience with marijuana. The need is now very clear for physicians to be involved in these social areas which are also significant health hazards.

Relating to the adolescent • Adolescents are not children and must not be treated as such.[15] Most physicians prefer to see adolescents alone but the choice of having the parent in the examining room is left to the adolescent. This marks a change in the traditional relationship between the physician and the parent and underscores involvement of the physician directly with the adolescent. This change in focus recognizes the right of the adolescent to be involved and expresses the expectation for the adolescent to begin assuming responsibility for his own health.

The crucial issue of confidentiality must be dealt with. Generally, when confidential issues arise, the adolescent is advised that what he or she brings to the discussion will be held in confidence; however, if a possibility arises that harm could come to the patient or to another person, the parents must be informed. The maturity of the adolescent rather than chronological age is considered a better guide for determining confidentiality and consent decisions.[16]

Interacting with some adolescents may be very difficult. At times it is obvious they are angry about being brought to the physician's office. Simply stating the obvious fact, "You seem very angry about being here. I'll bet you'd rather be doing a hundred other things right now," in a positive tone of voice is often sufficient to convey concern and change the tenor of the visit. Because adolescents are very concerned with their bodies, running comments confirming normalcy of the physical examination can be very reassuring.

Anticipatory guidance • Obviously mere knowledge on a subject does not necessarily change attitudes or behavior, but the physician can serve as a resource of information for the adolescent whose need is to establish his own identity and independence. The adolescent is encouraged to use the topics discussed during the anticipatory guidance portion of the visit as a springboard for discussion with his parents.

In my office-based private practice, anticipatory guidance is a routine part of well care. As the anticipatory guidance portion of the visit is initiated, an inquiry is made regarding any concerns or questions the patient might have. After dealing with these, the remark is made that "I have some things I'd like to discuss with you," and I write the acronym S-P-A-C-E-S in a vertical line, usually on the examining table paper (Table 1).

SMOKING. When discussing smoking, the relationship to cancer of the lung and emphysema is mentioned but more emphasis is given to the physiological effects, changes in heart rate, blood pressure, and carbon monoxide blood levels. The cosmetic effects, yellowing of teeth, increased wrinkling, and odor of tobacco that permeates the smoker are stressed as is the addictive quality of nicotine. "No thanks, I'm okay the way I am," is offered as an answer to the peer pressure situation.[17, 18]

Table 1.

S — smoking

P — pot, peer pressure

A — alcohol

C — chaperones, curfew, parent power, dating

E — exercise, diet, personal responsibility

S — sex, sexuality

POT. Pot is not a harmless substance and the effects on short-term memory, the amotivational syndrome, unrelenting peer pressure and the effect on psychological development are all discussed as well as the fact that marijuana use frequently precedes other drug use.[19-22]

ALCOHOL. The dangerous mix of alcohol and automobiles is discussed and a suggestion is offered on ways to get out of a car to call home for transportation when the driver is drinking. The unique susceptibility of the teenager to alcohol is mentioned.[13, 14, 23]

CHAPERONES, CURFEW, PARENT POWER, DATING. These subjects are covered in depth and are offered as proper areas for parental involvement. This is a time when adolescents question rules as a way of achieving independence, but at the same time they still have to live with the family and its rules.[1] Adolescents are expected to be home after supper on school nights but are allowed weekend extensions.[22] I recommend that parents stay up until the adolescent is home or that he or she at least be required to awaken the parents on returning home.[1, 22, 24]

EXERCISE, DIET, PERSONAL RESPONSIBILITY. Exercise, judicious eating and seat belt use as a continuing way of life are discussed. Community involvement and extracurricular activities at school are ways the adolescent can achieve self-respect. My favorite question is, "Tell me something you've done that made you feel proud of yourself?"

SEX. The statement that "there's more to sexuality than sex"[25] initiates this discussion. Psychosexual factors that differentiate male and female adolescents are discussed and an inquiry of sexual activity is made. Appropriate contraceptive advice or statements supporting nonsexual activity are offered. Peer and media pressure to be sexually active is recognized and commented upon.[26, 27]

Adolescence is recognized as a time to learn how to be responsible and independent and develop decision making abilities regarding behavior, morality, and establishing the person's own value system.

Summary • The adolescent offers an exciting and challenging opportunity to the physician. Maslow states that every person is at one time actuality and potentiality[28] and it is the potential of the adolescent as a productive human being that offers an exciting aspect for communication with him. When we as physicians perceive the adolescent to have potential, it is our duty to encourage it.

At times, as the difficult decisions of adolescence arise, it is advisable for the physician to offer moral guidance, especially in areas of drug and alcohol use and abuse.[29] If these areas are discussed by the physician as an authority but not in an authoritarian manner, then the adolescent will be more accepting of the advice.

Morality in sexual issues is another matter that must be considered. We must be cognizant of the fact that some adolescents do not always consider sexual activity a moral issue. Many variables influence this behavior such as sexual maturity, personal and family values regarding premarital sex, environment, and academic performance. Increasingly, many adolescents view sexual involvement as a matter of personal choice rather than a moral issue. The goal of counseling should be to help the adolescent achieve some sense of responsibility in making decisions about sexual activity.[30] For more detailed recommendations in discussing sexuality with the adolescent, refer to the article by Jensen and Robbins, "Ten Reasons why Sex Talks with Adolescents Go Wrong."[31]

Counseling the adolescent, while fraught with difficulty, is often satisfying and challenging and in addition offers an opportunity that is personally rewarding. Through the use of anticipatory guidance and an attitude of willingness the physician can serve the adolescent well in preparing for adulthood; success is most easily achieved by the physician who is willing to invest time, interest, and concern in the adolescent patient.

References

1. Glenn, S.: Strengthening the Family, Potomac Press, 1981, Bethesda, Maryland 20814.
2. Hockelman, R.A. et al: Profile of Pediatric Practice in United States, Am. J. Dis. Child. 137:1057-1060, 1983.
3. Friedman, S.B.; Phillips, S., and Parrish, J.M.: Current Status of Behavioral Pediatric Training for General Pediatric Residents, Study of 11 Funded Programs, Pediatrics 71:904-908, 1983.
4. Report by Task Force on Pediatric Education: Future of Pediatric Education, American Academy of Pediatrics, Evanston, Ill., 1978.
5. Telzrow, R.W.: Anticipatory Guidance in Pediatric Practice, J. Continuing Ed. Pediat. 20:14-27, 1978.
6. Paulson, J.A.: What Constitutes Patient Education? Pediat. Clin. North America, pp. 627-635, Aug. 1981.
7. Kimball, A.J. and Campbell, M.M.: Psychologic Aspects of Adolescent Patient Health Care, Clin. Pediat. 18:15-25, 1979.
8. Reisinger, K. and Bires, J.: Anticipatory Guidance in Pediatric Practice, Pediatrics 66:889-892, 1980.
9. Felice, M. and Friedman, S.B.: Adolescent as a Patient, J. Continuing Ed. Pediat. 20:13-30, 1978.
10. Cohen, M.I.: Adolescent Health: Concerns for the Eighties (commentary), Pediatrics in Review 4:4-7, 1982.
11. Committee on Adolescence 1977-1978: Statement on Teenage Pregnancy, Pediatrics 63:795-796, 1979.
12. Vernon, M.E., Green, J.A., and Frothingham, T.E.: Teenage Pregnancy: Prospective Study of Self-Esteem and Other Sociodemographic Factors, Pediatrics 72:632-635, 1983.
13. Leads from MMWR 32:49, 1983. Blood Alcohol Concentrations Among Young Drivers — United States, 1982, JAMA 251:23, 1984.
14. U.S. Department of Health and Human Services: Patterns of Alcohol Use Among Teenage Drivers in Fatal Motor Vehicle Accidents — U.S. 1977-1981, MMWR 32:344-347, 1982.
15. Rigg, C.A.: Approaching the Adolescent in the Office, J. Current Adolescent Med. 2:43-45, 1980.
16. American Academy of Pediatrics, Conference on Consent and Confidentiality in Adolescent Health Care, March 1981.
17. Wynder, E.L. and Hoffman, D.: Tobacco and Health, A Societal Challenge, New England J. Med. 300:894-902 (Apr. 19), 1979.
18. Wong-McCarthy, W.J. and Gritz, E.R.: Preventing Regular Teenage Cigarette Smoking, Pediat. Ann. 11:683-689, 1982.
19. DuPont, R.L.: Teenage Drug Use: Opportunities for Pediatrician, J. Pediat. 102:1003-1007, 1983.
20. National Institute on Drug Abuse: Marijuana and Youth Clinical Observations on Motivation and Learning, DHMS Publications #(ADM) 82-1186, 1982.
21. Petersen, R.C.: Marijuana — Continuing Dilemma, Am. Acad. Pediat. Annual Meeting, Oct. 14, 1979.

22. Manatt, M.: Parents, Peers and Pot, Proposed Parent-Teen Guidelines, pp. 96-98 (for the National Institute on Drug Abuse).
23. Council on Scientific Affairs (Report): Automobile-Related Injuries, Components, Trends, Prevention, JAMA 249:3216-3222, 1983.
24. NFP — National Federation of Parents for Drug-Free Youth, NFP Parent Group Starter Kit.
25. Greydanus, D.E.: Adolescent Sexuality: Overview and Perspective for 1980s, Pediat. Ann. 11:714-725, 1982.
26. Hofmann, A.D.: Managing Handicapped Adolescents with Impaired Body Image, Feelings 22:13-18, 1980.
27. Georgia Department of Human Resources, Fulton-DeKalb Hospital Authority, Family Planning Program: What's Happening Now, contract #10054, reprinted August 1980.
28. Maslow, A.: Toward a Psychology of Being, 2nd ed., Van Nostrand Reinhold Co., New York, 1968.
29. American Academy of Pediatrics Policy Statement: Role of Pediatrician in Substance Abuse Counseling, News and Comment, pp. 6-7, June 1983.
30. Emans, E.J.: Sexually Active Teenager, I. Developmental and Behavioral Pediat. 4:37-42, 1983.
31. Jensen, G.D. and Robbins, M: Ten Reasons Why "Sex Talks" with Adolescents Go Wrong, Medical Aspects of Human Sexuality, pp. 7-23, July 1975.

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Parent power and prevention: the national movement for drug-free youth

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ABSTRACT: The grassroots parent movement against drugs has grown from small, isolated neighborhood groups to over 4,000 organizations in all 50 states. The strategies are simple and pragmatic: educate parents about the negative health effects of drugs and alcohol on adolescents and organize parents in communication networks to counter negative peer pressure. Learning from their parents' concern and commitment, young people are joining the prevention effort. The teenagers want to bequeath a safer and healthier social scene to their little brothers and sisters. Together, these American volunteers are making a difference.

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In spring 1978, a small group of parents in Naples, Florida, nervously gathered in Bill Barton's office at his engineering firm. They had been called together because several had learned their teenage children were smoking marijuana and experimenting with other drugs. When confronted the children chorused, "Everybody does it. What's the big deal? Pot is harmless." The parents felt confused, helpless, and ignorant. Were the children right about marijuana? Were they hypocrites because "their drug" was alcohol? Does "everybody," that vague but powerful adolescent deity, really smoke pot? How could the parents be so blind? Should they back off as the popular psychologists on the talk shows advised and let the kids "do their thing"?

That night, grappling with these questions, the Naples parents made some tough decisions. They decided not to back off despite their teenagers' arguments, defiance, and "embarrassment." They decided to forget the "experts" and trust their gut instincts as parents. They vowed to learn the real facts about marijuana and, most importantly, to find out what in the world was happening to kids in the 1970s. That night, Florida's first parent group was formed and within six months Naples Informed Parents (NIP) embarked on a project that would have nationwide ramifications. They were determined that informed and committed parents could "nip" the drug epidemic "in the bud."

By 1984 parents in all 50 states had formed over 4,000 groups dedicated to goals similar to NIP's. As President Reagan stated, these groups form the last, best hope that our nation can turn the tide of the chemical flood that has engulfed so many young people. By making the parent movement for drug-free youth the cornerstone of U.S. national narcotics policy, the President and First Lady have stirred

interest and optimism in many countries that the plague of international drug trafficking will eventually be brought under control. For parents in Sweden, Jamaica, Colombia, Canada, and Zimbabwe are eager to join those in Naples, in saying, "No more. No more children lost to the drug culture."

The keys to the practical effectiveness of the parent movement are simple: first, sound health information on the effects of drugs and alcohol on adolescent development; second, parent networking to counteract negative peer pressure on teens. The health information is critical for it provides parents with a clear sense of their right and responsibility to protect their children's health. Teenagers should no more be able to argue their way into parental permissiveness about illegal drug and alcohol use than into permissiveness about measles shots and strep-throat medications. Parent networking is critical because it provides a communication link between parents that prevents their being the last to know when their own child drifts into trouble, and it provides consistency for basic behavioral expectations from family to family.

An effective prevention project first educates parents about current teen problems such as drugs, drinking, driving accidents, precocious sexual activity, venereal disease, low motivation, and suicide so the parents can talk with more realism, confidence, and humor about the difficult pressures and situations that teens face. (As with the Naples Prevent-A-Care program, the medical community can help by providing forums and clinical expertise for these meetings.) Next, an effective prevention project draws parents together in living rooms, swim clubs, school auditoriums, etc. to discuss areas of risk for local youngsters ("open" parties, cruising in cars, too-early dating, and empty houses) and to devise mutually agreed upon ground rules (reasonable curfews, responsible automobile use, age-appropriate entertainment, etc.). The result is a commonsense, constructive, but firm collective stand by those adults who care most about kids (parents). And that positive peer pressure from parents is proving stronger than the negative pressures from teenage peers, amoral merchandizers, and the hedonistic popular culture.

The long-range and international impact of the parent movement resides in its simplicity — any ordinary parent can do it. The emotional strength that drives thousands of volunteers in this unprecedented national movement comes from the strongest impulse in nature — the parents' primal instinct to protect their young. As businessman Ross Perot, voluntary head of the statewide parent education project in Texas, observes, "It's just like a mama bear protecting her cub." No wonder the multibillion dollar drug culture, the biggest criminal enterprise in history, is running scared. No wonder the sophisticated pro-drug lobbying groups, who dominated public policy in the early 1970s, feel outworked and outmaneuvered.

The most heartening recent development in the antidrug movement, however, is the growing number of young people who are getting involved in prevention. Many are concerned about younger brothers and sisters and hope to leave a legacy of a healthier and safer social scene for the next generation. These bright and idealistic youngsters have learned from the courage, resourcefulness, and energy of parents who stuck their necks out to change their communities. And, most promising for the nation's future, they are learning a basic civics lesson which seems to have been forgotten by many cynical social commentators of the 70s. "In a representative democracy, the solutions to serious social problems are absolutely dependent on the capacity of ordinary citizens to make extraordinary commitments to their neighborhood and nation. No one else can do it for them."

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Effective early intervention for adolescents harmfully involved in alcohol and drugs

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ABSTRACT: Nationwide studies have demonstrated a two decade increase in drug use by youth. This study describes the general characteristics of the 314 adolescents treated by Life Is For Everyone and explores the prognostic indicators of successful program completion.

Significant sex differences were observed: girls tend to present an "acting-in" symptomatology while boys demonstrated more "acting-out" tendencies; and females were most likely to start drug use at ages 12 or 13 while males were most vulnerable either at ages 10 and 11 or 14 and 15. Various interpretations accounting for these differences were offered.

Family composition does not appear to be related to whether or not a client is able to successfully complete the progam. Our data suggests that adolescents who are harmfully involved with drugs and who are aggressive in their interaction with parents are more resistant to therapeutic change than clients who interact with parents in a passive/avoidant manner. Further exploration of and study are needed to clarify these suggested differences.

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Nationwide studies, particularly those by the University of Michigan Institute for Social Research, have demonstrated a two-decade increase in drug use by youth. Also, well-recognized, have been the tragic end-stage consequences of drug addiction and alcoholism. Only in recent years, however, has there been increasing awareness of the tragic personal and social effects of drug usage by adolescents. What has been dismissed as harmless youthful experimentation and a "phase," is now being recognized as a profoundly disabling disease often resulting in death. In fact the 15-24 year-old age group is the only age group in the United States with increasing morbidity and mortality rates primarily related to drug use.

The fact that adolescents are particularly vulnerable to harmful effects from experimentation with psychoactive drugs is not surprising. Adolescence is characterized by anxiety, low self-esteem, conflicts between dependence needs and the desire to be independent, and fluctuations in ego strength. At a time when youths are attempting to develop self-awareness, competence, and a sense of identity, many are learning to cope with interpersonal problems and self-doubts by becoming intoxicated. The results are predictable and have been forecast by many, including Dr. Mitchell Rosenthal, President of Phoenix House Foundation, Inc.: "A sizeable number of young people will not mature as they should — will not make the intellectual gains they should — we can look forward to a growing population of immature under-qualified adults, many of whom will be unable to live without economic, social or clinical support. We will have in time an unmanageable number of emotionally or socially or intellectually handicapped citizens."

The predictions have been born out. The vulnerability of youth continues to be substantiated by such studies as those of Drs. Schuckit and Russell who found that the incidence of alcohol related problems, drug abuse and pyschiatric problems increased markedly the younger the teen began drinking alcohol.

Until recently little professional attention was being directed to the teenage drug user. Government resources and treatment facilities of the 1960s and 1970s focused on the opiate-dependent young adult. There was considerable under-estimation of the extent and consequences of teen drug usage. Counselors and psychotherapists usually considered drug use a symptom of underlying psychiatric disturbance and not as a major contributor. Traditional alcohol counselors have often held the view that the alcoholic must "hit bottom" before he or she is willing to accept help. Our experience and that of others, however, suggest that intervention early in the progressive disease of chemical dependence is effective, appropriate and necessary to prevent the disability and mortality of end-stage disease.

This paper describes our experiences in the rehabilitation of teens harmfully involved in drugs, structure of the L.I.F.E. program, characteristics of the population served, prognostic indicators of the program and the role of research in the design and implementation of effective intervention for adolescents.

Program description • The L.I.F.E. (Life Is For Everyone, Inc.) program was conceived and begun in 1980 by a group of parents who had witnessed the deterioration in their children and their families as a result of their children's drug use, experienced the frustration of attempting to discipline or reason with teens who seemed to have an emotional age of two years, and had been disappointed in the paucity of effective professionally guided treatment resources. They recognized the need for research into treatment methods, innovation in treatment, and the utilization of proven modalities and concepts, particularly those of Alcoholics Anonymous, the first and continuing success story in the treatment of alcoholism.

Among the initial goals of L.I.F.E. were: (1) to be as effective as possible for most teens, (2) to incorporate evaluation of effectiveness, (3) to involve the entire family in the treatment process, and (4) to be affordable and available to every family in the service area who would benefit.

L.I.F.E. employs a cognitive behavioral intervention in an outpatient peer group setting. The theoretical conception of the techniques and rehabilitation process are described by Drs. Nay and Ross, former clinical directors of L.I.F.E.[2] The peer group provides a positive peer influence and assists the client to become aware of alternative ways of relating to others without the use of drugs.

Client intake follows an extensive pre-intake interview and education with the parents, especially in order to assure commitment to treatment. During the first month the client receives a physical examination and standard laboratory testing. The MMPI is administered and, recently, more extensive psychological testing and interviews are provided. At the end of the first month, staff evaluates suitability for continued participation, need for special treatment approaches, and referrals for consultation. Clients with psychiatric disturbances are evaluated by a psychiatrist and often continue in the program with psychiatric supervision.

As the client progresses his or her achievements are recognized and rewarded with special privileges, responsibilities, and phase changes which are acknowledged by staff, group and parents. When the client becomes aware of the destructiveness of past behavior and makes a commitment to change, he progresses to the second phase and returns to live with the parents who have learned the rules of the program, have begun to develop their own self-awarness, communication skills, assertiveness, and effective discipline and child management techniques.

Each client is assigned a primary peer counselor who is responsible for frequent evaluation. Progress is monitored and discussed in weekly staff meetings. Clients also receive considerable "feedback" from other clients.

The goal of the second phase is to reestablish and rebuild family relationships; third phase, returning to school or work; fourth, learning and practicing the constructive use of leisure time and building new friendships, and fifth, emphasizing giving back to others by sharing, being a positive role model and taking responsibility for others. It is important that the client has ample time to assimilate new styles of thinking and behavior and practice the skills and techniques he has learned in the program in order to maintain them after leaving the program. Several studies have demonstrated a linear relationship between program tenure and post-treatment outcome with respect to decreased drug use, increased employment, decreased crime and improvement in interpersonal relations. As the client progresses through the program, he is expected to demonstrate increased self-control as the program relaxes controls. After "Seven Stepping" (completion of the formal phases of the program), he enters the Seven Step Society and functions more autonomously but still has his group which meets weekly, for "raps," for planning social and recreational activities, and providing support. (The "Seven Steps" are a condensation of the 12 used by AA.) The client is monitored closely the first six months following completion of the program.

Population characteristics • The subjects chosen for this descriptive pilot study were the first 314

clients who were admitted to the L.I.F.E. program and had enough time to have completed the program. Table 1 provides a detailed description of the types of information gathered.

The average client starts drug usage at the age of about 12½ years, does the drugs for 3½ years and enters our program at age 16. We have treated clients who began drug use as early as age seven and as late as age 17, and who were as young as 11 or as old as 22 at the time of entry. The "typical" client tends to have abused a large variety of drugs, with alcohol and marijuana heading the list. The average boy tends to have started with alcohol as his primary drug of abuse and then as he became older tended to primarily use marijuana. Girls, on the other hand, tended to use alcohol as their primary drug of abuse regardless of their age. We have more male clients than females (males comprise 57% at entry). The majority have shown impairment in school performance concurrent with drug usage (82% developed a negative attitude toward school, 79% were making lower grades, 77% had a history of skipping classes). A relatively large percentage (49%) had been suspended prior to program entry and had a history of running away from home at least once (49%). The majority (65%) had been sexually active. Fifty nine percent of our clients had received some type of outpatient counseling prior to enrollment in the program.

As would be expected, parents reported considerable change in family relationships once their children had started drug usage. The majority of clients avoided family gatherings (65%), avoided responsibilities (82%), accused parents of "hassling" (88%), and manipulated parents in order to hide activities (74%). Parents also noted changes in personality concurrent with drug onset. The majority of clients had changed their friends, (67%), started using foul language (70%), started lying (89%), changed their taste in music (78%), become irritable (87%), selfish (83%), and displayed a loss of motivation (87%).

One of the commonly held beliefs surrounding teenage substance abuse is that drug involvement is the result of a break-up in the nuclear family. In the current study, the families who have children harmfully involved with drugs do not appear to be significantly different from the population at large with regard to the number of divorces, separations, or deaths. Seventy percent of our clients come from two-parent households (1981 census figure: 75%) and 18% come from a single parent household (1981 census figure: 20%). It would appear that L.I.F.E. program parents and clients are representative of the larger population and as such the current data suggest that harmful drug involvement is not necessarily associated with a particular type of family composition. Other family factors, however, do appear to be significant, and will be discussed at a later point.

Sex differences • We were particularly interested in how males and females progressed in our program. Females have traditionally had better treatment outcomes than males in residential psychiatric programs and outpatient counseling. This is most commonly ascribed to sex role characteritics (i.e., females are seen as more compliant, having "acting-in" symptomatology while males are seen as less compliant and presenting more sociopathic symptomatology). As would be expected in a drug treatment program, almost all our clients have some sociopathic or at least "oppositional" characteristics; however, it is clear from our data that the "acting-out" tendencies are much stronger for the males in our program and are negatively correlated with completion of treatment.

Prior to program entry, males were more likely to make lower grades than females, to have been suspended from school, to have a history of traffic violations, to have committed vandalism, to have been involved in breaking and entering, involved in burglaries, had more arrests, more convictions, and more likely to be in trouble with the law at the time of intake (refer to Table 1 for chi-square levels of significance). Males were also perceived by parents to have less motivation and to be more selfish. The only "acting-out" behaviors where the females were reported by parents as having a higher incidence than males were sexual intercourse (75% of females versus 58% of males) and running away from home (65% of females versus 46% of males). It seems probable that parent awareness was greater for female sexual activity due to issues of pregnancy and gynecological problems. Parent awareness of shoplifting was about equal for males and females (23% of all males, 21% of all females). Thus, it is clear that acting-out behavior is more frequent and severe for males who enter our program than for females. Perhaps because of this, more males enter our program (57% of all intakes are males) but fewer males complete the program (49% of all males complete versus 63% of all females).

The data showed no other systematic differences in symptomatology between males and females. There was one demographic difference: females were most likely to start drug use at ages 12 or 13 while boys were most vulnerable either at ages ten and 11 or 14 and 15. This is somewhat consistent with all studies of psychological vulnerability showing childhood to be most difficult for boys while adolescence is most difficult for girls.[3] We suspect that the boy who starts drugs at ten or 11 may be very different from the one who starts at 14 or 15, and we plan on conducting subsequent studies to look at this relationship.

Prognostic indicators • At this point in time the sole source of information pertaining to program effectiveness is provided by the number of clients

Table 1. — Relationship of variables to treatment outcome.

Variables	Chi-Square Analysis	
	Relationship to Outcome	Level of Significance
Basic Demographic		
age	—	—
*sex	females (positive)	.018
age at time of onset drug use	—	—
School History		
highest grade completed upon admission	—	—
changes in grade average with drug onset	—	—
*negative attitude toward school	negative	.006
*history of skipping classes	negative	.030
*history of suspensions	negative	.002
history of being expelled	—	—
Family History		
natural, step, adoptive family	—	—
*drug use with siblings	positive	.005
*parent drug use: (illicit drugs)	negative	.011
history of parents in counseling	—	—
*history of conflict	negative	.018
withdrawal from family	—	—
Client's Sexual Behavior		
intercourse	—	—
pregnancy	—	—
birth control pills	—	—
Personality and Behavior		
changes in friends with onset of drug use	—	—
*foul language	negative	.005
*lying	negative	.015
changes in music with onset of drug use	—	—
*loss of motivation	negative	.011
*selfishness	negative	.001
Law Breaking		
*traffic violations	negative	.013
vandalism	—	—
shoplifting	—	—
breaking and entering	—	—
*burglary	negative	.013
*currently in trouble with the law	negative	.045
*formal charges or arrests	negative	.036
convictions	—	—
run-away from home	—	—
court-order to complete treatment	—	—
child placed under state agency authority	—	—
Previous Treatment		
residential drug treatment	—	—
*residential psychiatric	negative	.038
outpatient treatment	—	—
Program Variables		
*length of time on phases of L.I.F.E. program	3rd phase (positive)	.033
*number of nonmedical incident reports	negative	.001
number of start-overs	—	—
number of times returned to lower phases on program	—	—
date of program entry	—	—

* indicates those variables which are either positively or negatively related to treatment outcome

who have successfully completed the L.I.F.E. program. A comprehensive review of adolescent psychiatric hospital follow-up studies conducted by Gossett, Lewis, and Phillips supports such a measure.[4] These authors conclude that successful completion of treatment is one of a number of predictors of later adult functioning.

Table 1 lists all the variables included in the present study. Those with an asterisk are either positively or negatively related to treatment outcome. A negative relationship between a variable and treatment outcome suggests a negative correlation between the two. Thus, for example, those clients who have been suspended from school tend to be less likely to successfully complete the program. The smaller the level of significance (based on a chi-square analysis) the more powerful the relationship between the variable and treatment outcome. Only levels of significance equal to or less than .05 are herein considered to be significant and are recorded in the table.

Of the basic demographic variables, only sex was significantly related to successful outcome. The L.I.F.E. program appears to be more effective with females than males. Sixty three percent of female clients Seven Stepped the program as compared to 49% of male clients. This difference in program effectiveness is significant at the .018 level. Interpretations of this difference will be explored in the discussion section.

In terms of school history, behavioral and attitudinal problems are clearly negatively related to treatment outcome. It is interesting to note that academic problems (i.e., making lower grades upon drug onset) were not significantly related to treatment outcome. It may be that lowering of grades is one of the first signs of harmful drug involvement and as such is less resistant to change than the attitudinal and behavioral indices of school problems. This interpretation would suggest that early intervention is crucial.

Family composition does not appear to be related to whether or not a client is able to successfully complete the program. There is, however, a type of family dysfunction which appears to be significant. Clients coming from families marked by aggressive and rule-related conflicts (i.e., refusal to do responsibilities, accusations of hassling, and manipulation) tend to be less likely to successfully complete the program as compared to those clients who do not have such a history. On the other hand, clients from families marked by passive communication problems (avoiding family get-togethers, sharing with siblings and being seen with parents) seem to be less resistant to treatment as measured by their ability to successfully Seven Step. These findings suggest the possibility that the program is more effective in teaching withdrawn members how to communicate with each other and relatively less effective in teaching aggressive members how to manage their conflicts more constructively. Finally, it was found that clients whose parents were involved in illicit drug use tended to be less likely to successfully complete the program. This finding clearly speaks for itself.

The personality and behavior items investigated in this study were measures of qualities typically associated with drug involvement. Of these, use of foul language, lying, loss of motivation, and selfishness were the most resistant to change as measured by the fact that fewer of those engaging in these behaviors were able to successfully complete the program. Levels of significance for these findings are listed in Table 1.

Those clients prior to program entry, who had been formally charged or arrested tended to have a more difficult time successfully completing the program than those who had not had such legal problems. This finding may again suggest the possibility that those clients who are further along the "addiction ladder" are more resistant to the program. It was also found that instances of law-breaking including burglary and traffic violations were engaged in by clients who tended to be less likely to Seven Step.

In terms of previous treatment experiences, only prior residential psychiatric treatment was negatively correlated with treatment outcome. Those who had experienced prior inpatient psychiatric treatment tended to be less likely to Seven Step the program. This finding may represent the fact that more severe pathology is more resistant to change.

The problem areas thus far discussed tend to demonstrate a common theme: The more severe the pathology (either psychiatric or sociopathic) prior to program entry the less likely the client is to complete the program. McLellan et al in a study of male alcoholics and drug addicts found that "patients with low psychiatric severity improved in every treatment program. Patients with high severity showed virtually no improvement in any treatment"[5]. Such findings strongly suggest that early intervention in the addiction process will result in a more successful treatment outcome.

Discussion • The "average" client tends to be harmfully involved with a large variety of drugs. This pattern seems to be spearheaded by the adolescent's primary involvement with alcohol. It may be that the use of alcohol impairs judgement to the point of indiscriminate drug usage. The adolescent who is harmfully involved with drugs can be readily identified by impairment in school performance, involvement in legal violations, and deterioration of family relationships. The average client in the program shows the typical symptom cluster reported for adolescents harmfully involved with drugs, "They

have impaired functioning in school performance, family relationships and rule-following behavior (legal involvements)."[6,7] In addition, they are perceived by their parents as undergoing personality changes and changes in friendship and music patterns.

It should be emphasized that our data suggest that the problem of drug abuse is not limited to a certain type of family composition. Two parent households and single parent households have an equal rate of adolescent drug abuse incidence (relative to overall population differences). Families do seem to differ, however, in the type of dysfunction which is conducive to or a reflection of adolescent drug abuse. Our data may suggest that adolescents who are harmfully involved with drugs are more likely to come from families marked by aggressive (versus passive) symptomatology and that they are more resistant to therapeutic change than clients coming from families marked by passive/avoidant tendencies. Further exploration and study are needed to clarify these suggested differences.

Our data clearly indicate that prior to program entry, boys tend to "act-out" criminally (i.e., legal violations) more so than girls. There is some indication that girls may act-out sexually (including more run-away episodes) more so than boys. Of particular interest is the fact there appears to be different critical periods for boys and girls. Females were most likely to start drug usage at ages 12 or 13, whereas boys were most vulnerable either at ages ten and 11 or at 14 and 15. This may suggest that early intervention prior to these critical periods is essential and that different treatment strategies may be necessary depending on sex and age of onset. This possibility is strongly supported by the facts that: (1) the program is differentially effective with boys and girls, (2) girls require more time on phase 2 (working on family relationships) than do boys, and (3) males 12 or younger do not respond well to the program (as currently structured).

The prognostic indicators suggest that the program is more effective with certain types of adolescents than with others. The more severe the pathology (either psychiatric or sociopathic) prior to program entry the less likely is the client to successfully complete the program. The program is more effective with girls than with boys. Finally, certain program variables are clearly related to treatment outcome. These findings have been incorporated into our screening and assessment procedures. At the end of the first month of program involvement, staff evaluates each client's suitability for continued participation and his need for special treatment approaches.

The exploration of program variables was of particular interest for a variety of reasons. The fact that the number of nonmedical incident reports filed on a particular client during his program was positively correlated with treatment outcome suggests that the inhouse incident reporting procedure tends to accurately reflect client progress and that this may prove to be a very valid monitoring instrument to indicate when special care or treatment is needed in the course of the program. Of related interest was the fact that the third phase appeared to be of critical importance for most of our clients. The longer the average client spent on this phase the more likely he or she was to complete the program. This obviously suggests that special care must be taken during this critical period. The importance of the second phase for our girl clients has already been discussed. Finally, the possibility that there is a point of diminishing returns in the treatment process of adolescent abusers has obvious clinical and program policy implications.

Conclusion • This exploratory study has raised more questions than it has answered. The findings and suggested interpretations should be considered as hypotheses to be further tested. Within this context, certain plans and suggestions will be made.

There is a need to refine and explore certain measures including: severity of drug involvement (reflecting both the intensity and duration of different types of drug involvement); types of family dysfunction; differential patterns of drug abuse (as related to different ages of onset and observed sex differences); different types of program progress patterns; etc. Problems of patient-parent discrepancies in reporting information must be addressed. More sophisticated statistical analyses are needed to study interaction effects and to provide predictive regression equations. Special pilot programs need to be created and their impact measured so as to maximize overall treatment effectiveness. Long-term follow-up as well as more comprehensive measures of success need to be implemented.

Is early intervention the key to effective drug treatment? What types of treatment are most effective for what types of client? Can a pre-abuse, high-risk profile be determined? When should alternative treatment modalities be employed? To what extent are our clients representative of a larger population? Before these questions can be answered more research needs to be conducted.

(References available upon request.)

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A model school-based comprehensive alcohol/drug abuse prevention program

Robert Holsaple, M.S. and Mrs. Mae White, M.A.

ABSTRACT: No single method of prevention is effective in reducing alcohol/drug abuse among school-aged children.

An effective three-pronged program, consisting of the following components, was developed in Broward County.

1. THE INFORMATION COMPONENT, a curriculum of factual information regarding alcohol and drugs presented to grades K through 12 in age-appropriate terms and concepts. Facts on building and enhancing a positive self-regard are also included because it has been found that students with poor self images frequently resort to drug and alcohol abuse.

2. THE PROCESS COMPONENT, a program of peer counseling. Students with leadership ability receive a full year of training, with credit, and then serve as counselors to problem students.

3. THE FAMILY/COMMUNITY SERVICE COMPONENT, a program for parent education and counseling. School buildings are used in off-hours, thus providing low cost, convenient and anonymous facilities.

By developing all three facets of this comprehensive program, an environment has been created in which students have been helped to feel more worthwhile and knowledgeable. This significantly reduces the risk of alcohol and drug abuse.

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Research has shown that no single prevention or educational approach has been effective in reducing alcohol or drug abuse and other forms of dysfunctional behavior frequently associated with it.

The Broward County School System has accordingly developed and implemented, under the direction of Bob Holsaple, a three-pronged program, now in its fourth year, which has proven to be extremely effective. In fact, in a nationwide survey conducted by the National School Resource Network in 1982 of 1,800 school-based programs, only 21 were found "that work" and the Broward County program was the only one which was cost-effective and reached students from kindergarten through high school. The state Department of Education has proposed that the program be used as a model in schools throughout Florida. Portions of the program were recorded in the Congressional Record by Circuit Court Judge Hugh Glickstein to be used at the national level.

The program is based on a combination of strategies and shared responsibilities of the school system, the students themselves, their parents, and the community at large. The combined efforts have produced the three components which are: Information, Process, and Family/Community Service.

The Information Component • A curriculum of factual information regarding alcohol and drugs is a key element to prevention. A common working vocabulary provides a basis for communication within the classroom, between peers and students and parents. Six years ago the Broward County School Board established alcohol and drug education curriculum as a priority. The next year the Board furthered its commitment with a precedent-setting decision, at least within the state of Florida. It mandated the provision of alcohol/drug education for grades K through 12.

The primary grades curriculum, in addition to age-appropriate alcohol and drug information, is geared toward basics of building and enhancing positive self-regard. Students with poor self-concepts who are unaware of or perceive limits to their own resources and are subsequently frustrated in their attempts to cope with troublesome situations frequently resort to drug use.

Teachers are guided in terms of content but are allowed flexibility in format. Typically, the information is interwoven into a variety of subjects; however the program is sequentially developed. As students progress through the grade levels, the content and time devoted expand. The curriculum vehicle for this component is the Comprehensive Health Education Program K-12.

By the time students reach high school, nine weeks of the required health education courses are devoted specifically to alcohol and drugs and mental health issues.

The Process Component • Student peer counselors form the core of this component. Potential peer counselors are selected from the school population on the basis of natural leadership ability. Consequently many who receive the year-long training are not necessarily the "good" students. Students in the training program receive a full year of academic credit under the social studies curriculum. Training, provided by school personnel and outside licensed consultants, includes counseling skills, group dynamics, active listening, motivation and how to make referrals.

Students identified with problems are assigned to a peer counselor who typically maintains a "caseload" of three to five. Their parents are engaged in a 12-week effective parenting course, a necessary support for gains made within the school system.

Peer counselors also facilitate "rap groups" for students who want a safe, confidential place to talk about their concerns. A semistructured agenda for the groups emphasizes self-evaluation, goal-setting, values clarification and problem-solving skills.

The peer counseling component of the comprehensive program now exists in 23 high schools. The results are enviable. A decrease in dysfunctual behavior of 100% to 200% has been reported. In addition, academic performance by those students referred to the program has improved dramatically. The TIPS program (Techniques of Intervention and Prevention Strategies) was cited as the single, most comprehensive and effective prevention effort in the country.

The Family/Community Service Component • The family component is designed to work with parents during the children's early years. Research indicates that behavior is shaped and formed during the early years of a child's development. Three modalities comprise the family component: Primary Parenting (an 8-12 week parent-effectiveness course), Single Parenting, and Family Counseling Centers (provide intensive, individual family therapy for those clearly experiencing problems needing professional assistance).

There are 14 parent education programs and three family counseling programs in the Broward County School System. By helping parents develop a sensitivity to their children's needs, they are able to function in a more supportive role. Familial support is crucial to development of a positive self-image in youth.

The Family Component has continued to expand services since inception. This is due in part to the fact that it incurs no overhead expenditures for the services provided. Community education facilities are used in the evenings and other off-hours for the parenting classes. An added benefit of this arrangement is the anonymity the settings provide, since many other night classes are taking place at the same time. These classes are conveniently located in 13 different cities in Broward County. The settings are safe and nonstigmatic. Well-qualified school personnel serve as instructors and group leaders.

Conclusion • There is no single approach to the prevention of alcohol/drug abuse among youth. The Broward County School System has developed a comprehensive program which: (1) provides, over a period of many years, a solid foundation of factual information regarding alcohol and drugs, (2) generates options for intervening with "problem" children, and (3) incorporates families into a supportive role in their children's lives. In this type of environment, where they are made to feel knowledgeable and worthwhile, teenagers develop a sense of purpose and direction. This, in turn, reduces the risk of alcohol and drug abuse and other forms of dysfunctual behavior.

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Cocaine: today's drug

Lynn Hankes, M.D.

ABSTRACT: This paper emphasizes the dramatic increase in cocaine abuse and addiction in recent years. Historical perspective is updated to cocaine's widespread current appeal which appears to be associated with the particular mystique of this drug. Its allure stems from a unique mixture of an intriguing history, its high price and status, an accepting culture, and the myth that it offers its users an harmless high. Discussion follows on the substance, its metabolism, effects, medical consequences, and other dangers. The acute cocaine reaction and chronic cocaine toxicity are reviewed, and treatment for both suggested. Lastly, the cocaine "abstinence syndrome" is explored and post-detoxification issues mentioned. The author defines addiction and outlines general treatment objectives as well as their particular application to cocaine.

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Meteorically, cocaine has risen to the premier position on today's drug abuse galaxy of stars. Testimony to this fact is illustrated by this notoriety: two *Newsweek* major articles, two *Time* major articles, NBC-TV Documentary, ABC-TV Documentary on the Cocaine Cartel, the cocaine-only drug conference in Atlanta, birth of Cocaine Anonymous self-help groups in major metropolitan areas, and establishment of a 1-800-COCAINE research hotline in New Jersey taking over 1,000 calls a day. In resent years, there has been a dramatic increase in the use of cocaine by a broad cross section of the American populace. Its widespread current appeal appears to be associated with the particular mystique of the drug. Its allure stems from a unique mixture of an intriguing history, high price and status, an accepting culture, and a belief that it offers its user an harmless high.

Early cocaine use • Today's drug was indeed yesterday's drug as well. We are now experiencing the third or fourth cocaine epidemic. Historically, it dates back 5,000 years ago. Its real claims to fame occurred in the 19th century. Angelo Mariani, a Corsican chemist, may have come the closest to "turning the world on" by inventing an elixir with coca and alcohol. Numerous medical giants including Freud, Koller, Corning, Halsted, Crile, and Cushing praised the merits of the discovery of the age, the benefit of which to mankind would be incalculable. Its opponents labeled it the third scourge of mankind (after alcohol and morphine). The New York *Times* stated that it wrecks its victim more swiftly and surely than opium (1908). Coca-Cola® went "clean" replacing coca with caffeine, the Harrison Tax Act erroneously classified it as a narcotic and the intervening years have been inundated with debate about its abuse and addictive potential.

Current use • In the United States between 1975 and 1980, the number of individuals seeking treatment for cocaine abuse increased fivefold, the number of emergency room admissions fourfold, and deaths fourfold as well. At least one million are now profoundly dependent on cocaine, a new corps more numerous than heroin addicts. About 10% of high school seniors are regular users. Cocaine has become a $25 billion business ranking it in sales among the top ten U.S. companies. No longer is it the recreational drug of the affluent; 20% of blue collar workers engage in frequent cocaine misuse. Men outnumber women by a 2:1 ratio. The emerging "profile" appears to be a white, college-educated man in his 30s with an annual income of $25,000. Recent bumper crops in South America will alter the supply-demand ratio to lower the price and augment the already massively escalating epidemic.

The substance • Cocaine is a member of the tropane family of alkaloids and is obtained from the leaves of the erythroxylon coca plant indigenous to the mountain slopes of Central and South America. It has been mislabled a narcotic, from the Greek, *Narkotikos*, meaning benumbing, deadening, and sleep producing as in opiate torpor. A wired "cokehead" would hardly fit this description. Pharmacologically it is a CNS stimulant and a local anesthetic. Street cocaine is sold for about $100 per gram but is obtained at about 25% less here in Florida. It is rarely pure and is cut (stepped on) with various adulterants including local anesthetics, other stimulants, sugars, and miscellaneous substances. In practical terms, one "line" of street coke weighs between 5 and 20 mg, one coke "spoon" slightly less. Freebasing usually involves a single "hit" amounting to between 60 and 100 mg.

Metabolism • Cocaine is readily absorbed from all mucous membranes, although concomitant local vasoconstriction limits its rate of absorption. Despite this fact, absorption may easily exceed the rate of detoxification and excretion leading to high toxicity. Cocaine undergoes rapid biotransformation in the body. Its two main metabolites, ecgonine and benzoylecgonine, are excreted in the urine in amounts equivalent to one fourth to one half the original dose within 24 to 36 hours. Depending on urine acidity, 10% to 20% of cocaine is excreted unchanged. Addicts attempt to enhance excretion to avoid detection by consuming large volumes of cranberry juice or ingesting megadoses of vitamin C. Physicians treat in similar fashion with intravenous ammonium chloride. After 100 mg of IV cocaine, a plasma peak occurs at five minutes and the distributional half-life is 20 to 40 minutes. The most popular routes for abuse purposes are intranasal (snorting), intravenous (running), and freebasing inhalation (smoking).

Effects • Cocaine is a beguiling drug which does not result in hangovers, lung cancer, or holes in the arm. Instead, a user takes a snort and for the next 20 to 30 minutes there is an increase in drive, sparkle, and energy without a feeling of being drugged. Reported subjective effects include mood elevation to the point of euphoria, decrease in hunger, increases in energy and sociability, indifference to pain, and significant decrease in fatigue. Users experience a feeling of great muscular strength and increased mental capacity leading to an overestimation of their capabilities. The powerful experience of the cocaine high can lead the user into a pattern of regular and escalating use. The most commonly reported side effects of regular use include anxiety, dysphoria, suspiciousness, disruption in eating and sleeping habits, weight loss, fatigue, irritability, concentration difficulties, and perceptual problems. Increasing use may lead to hyperexcitability, marked agitation, paranoia, hypertension, and tachycardia. As the individual becomes more and more "strung out," alcohol, other sedatives, or narcotics are often taken to combat the overstimulation. Paranoid psychoses are manifested by a variety of symptoms such as visual distortion and hallucinations ("snow lights," geometric patterns, etc.), tactile hallucinations (sensation of insects on, in, or under the skin — cocaine "bugs"), delusions (being chased by the police — "bull horrors"), and violent behavior. Cocaine interacts with the catecholamine neurotransmitters, norepinephrine and dopamine, and alters normal interneuronal communication. It augments the effects of these catecholamines, probably by blocking (or prolonging) reuptake at the synaptic junction, leaving an excess of these neurotransmitters to restimulate receptors. Dopamine is a precursor of norepinephrine and is found in the corpus striatum — part of the network governing motor functions — and in that portion of the hypothalamus regulating thirst and hunger. Norepinephrine is the prime neurotransmitter of the ascending reticular activating system (RAS), regulating mechanisms of external attention and arousal. It acts as a vital transmitter as well in the hypothalamus which regulates body temperature, sleep and sexual arousal and, in general, mediates emotional expression. It also mediates neural activation in the median fore-brain bundle of the hypothalamus which is believed to serve as an individual's "pleasure center."

Medical consequences • When we look at a drug taken, not prescribed, for a mood-behavioral change, we consider the following: first, the potential for overdose; second, the potential for acute toxicity; third, physical derangements; fourth, its effects on mental status; and fifth, behavioral modification. That is, how much does it incapacitate a person or hinder his or her ability to function in an environ-

ment which was not a preexisting problem? Acute consequences include: hyperpyrexia; hypertension with possible CVA, arrhythmia or myocardial infarct; accidents because of impaired judgment and timing; and the dangers which lurk around some less than desirable purchase zones. Seizures are common and often progress to status epilepticus. Chronic complications depend on purity, route of administration, sterility, and frequency of use. Users confuse cleanliness with sterility. One of the frequent chronic medical complications is not strictly medical but dental. Cocaine is a powerful local anesthetic and users neglect their teeth often presenting with missing fillings, holes in teeth, loose teeth, impaction with inflammation, and even periodontal abscesses. A detailed oral examination is mandatory. Malnutrition is common because food intake is ignored. Most patients are thin, rarely obese, some are emaciated; 73% have at least one major vitamin deficiency, usually pyridoxine followed by thiamine and then ascorbic acid. Intranasal users develop rhinorrhea, nasal septal necrosis and perforation, hoarseness, aspiration pneumonia, and frontal sinusitis. Routine chest and frontal sinus x-rays are suggested. Freebasing often results in burns from explosion of the volatile ether used in preparation of the base. Chronic smoking patients should be evaluated with pulmonary function tests. Intravenous users are subject to infections of the skin, lung, heart valves, brain, and eye with multiple unusual bacteria and fungi. Some 86% of IV coke users have antibody evidence of prior exposure to hepatitis B. Talc and silicone adulterants produce granuloma formation in the lungs, liver, brain, and eye. Cocaine is metabolized by the liver and excreted by the kidney; any preexisting dysfunction will exacerbate most conditions previously discussed. Patients, just prior to admission, will often "tank-up," that is, use very large doses in anticipation of cold turkey. This increases the toxicity potential and some centers are reluctant to admit on weekends and nights unless medical supervision is available. The lethal dose of cocaine is about 1.2 gm but severe toxicity has occurred with an average dose of 20 mg. Tolerance and route of administration however play an important role in the lethal dose. Sudden death from cocaine is so sudden that the only medical person to see the patient is often the coroner. Death occurs from status epilepticus, respiratory paralysis, myocardial infarction or irritability, and rarely anaphylaxis. It does not appear that antiepileptic medications will reduce or block cocaine related seizures. The combined chronic lack of sleep and throat anesthesia may interact to cause a deep "crash" (sleep) which is accompanied by a flaccid jaw-induced airway obstruction (suffocation) or failure to remove secretions (drowning). The number of deaths involving cocaine with other drugs has also rapidly increased but not by as much as cocaine-related homicide victims. Death can and does occur in young people who drink and use cocaine. The cocaine keeps the person awake enough to continue drinking and try to drive home; the cocaine wears off before the alcohol and the high blood alcohol level oversedates causing a fatal accident. Often only the BAL is analyzed, falsely attributing the death to alcohol alone. Concomitant use of narcotics is an attempt to boost the cocaine high, or to self-medicate its side effects, often results in disaster. Finally, another mechanism involved in cocaine-related deaths is cocaine-related suicides. These dependent individuals feel hopeless and helpless. Suicide may be seen as the only solution to deteriorating health, personal-domestic-financial situations. However, fear of disability or disease from various and sundry sources will not deter use since most users discount these medical reports or doubt that they will occur to them.

Other dangers • The lifestyle that civilized man generally accepts as normal involves major efforts to obtain and enjoy food, water, shelter, friendship, and a sexual partner. It is assumed by brain researchers that a major function of the brain's reinforcement centers is to make it possible for the individual to strive to achieve these goals despite the fact that their availability is limited. Cocaine's main danger is to by-pass the normal reinforcement process. In doing this, it reprograms or reprioritizes the person so that getting cocaine is supreme and all normal drives subverted. People and their cocaine problems can be separated on the basis of access. Pharmacists and doctors who have tried cocaine or who have access to pharmaceutical cocaine have a special kind of problem. People who have a lot of disposable income (performers, actors, rock stars, etc.), have a different problem which relates to the monkeys — unlimited access. They can easily end up addicted. Cocaine is a drug of disposable income — what you have the drug will soon dispose of. The remainder of the population of users may be temporarily saved from this fate by lack of resources or access. But if the price drops or availability changes, all bets are off.

Many physicians and users debate whether cocaine is addicting, the underlying premise being that if it is not then it is not dangerous. The state of the art definition of addiction encompasses three concepts: compulsive use, loss of control in the face of the drug, and continued use despite adverse consequences. Using this, cocaine is obviously very very addicting. It lends itself to reinforcement. Toxic manifestations do not even curtail use. Taking cocaine stimulates taking cocaine. Drug-craving and drug-seeking behavior is notable with cocaine clearly indicating high level of psychological dependence. It is this effect coupled with cocaine's property to reinforce its own abuse which leads to disaster. Regular

users, especially high dose snorters, freebasers, and injectors, generally want to maintain the elation. Cocaine's price and pharmacology do not lend themselves to a self-regulated maintenance program. So if price and access can be conquered users may "base" continuously for days or inject IV every ten minutes. For some, the anxiety, suspiciousness, and hypervigilance becomes overwhelming. Even as the user comes down and recalls the paranoid experience, he will generally start up again with the notion that this time he will stop short of insanity. Success oriented nondrug using people may discover cocaine and in less than two or three years find themselves hopelessly involved in illicit activities or facing incarceration. Consistent use can result in a severe depressive reaction which may be due to depletion of norepinephrine stores. This may lead to another temporary "cure" perpetuating the habit. Others with mild depression will self-medicate with cocaine. They quickly learn that they are nothing and that the drug is everything. Any subsequent success is misattributed to the drug and these abusers come to believe that normal functioning without the drug is near impossible.

Acute cocaine reaction • Medical intervention must be without hesitation and directed to support of cardiovascular and respiratory functions. Needed are a source of positive pressure ventilation, supplemental oxygen, proper endotracheal equipment, suction, a stretcher that will allow Trendelenburg position, IV infusion lines, continuous EKG monitor, and proper medications. All drugs should be titrated to clinical need. For signs of advancing CNS stimulation, 2.5 to 5.0 mg diazepan may be given IV and repeated as many as four times at 5 minute intervals. If impending disaster is perceived, the ultrashort acting barbiturate, thiopental, 50 to 100 mg, along with the depolarizing muscle relaxant, succinylcholine, 40 to 100 mg, may be given for immediate control of the airway and ablation of convulsive movement. Should tachycardia, hypertension, and/or ventricular ectopy appear, 1 mg propanolol by IV bolus may be given. This may be repeated six times at 1 minute intervals. Titrate to a diastolic pressure of about 90, and an apical/radial pulse around or less than 100. Lidocaine may be employed to supress ventricular ectopy in a dosage of 50 to 100 mg IV bolus; keep IV lines open in order to administer 2 to 4 mg lidocaine per minute, prn. Core temperature should be monitored with a cooling blanket, fans, and cold sponging available. Metabolic acidosis should be treated with bicarbonate. In administering drugs, remember the dangerously high levels of catecholamines. CNS and cardiovascular events must be scrupulously watched.

Chronic cocaine toxicity • A commonly seen clinical phenomenon is a patient three to 14 days into a binge who exhibits signs of late Stage I (premonitory to the collapse of Stages II and III). These individuals show hyperkinetic behavior, tachycardia, hypertension, tachypnea, dyspnea, tics, jerks, tremors, stereotypical movements, distorted perception, and, possibly, violent protective behavior which is delusional. Such patients are at prime risk for cardiac arrhythmia, CVA, and high output CHF. Such cases of adrenergic or dopaminergic storm have been found to respond dramatically to the lytic effects of propanolol. Again, careful monitoring is mandatory. Give propanolol either in slow IV increments of 1 mg at 1 minute intervals up to a total of 6 mg or orally in a dosage of 40 to 80 mg at 4 to 6 hour intervals for a period of up to 1 week with a pulse of 90 or less the goal. Give sips of 5% glucose solution or perhaps cranberry juice rich in benzoic acid. Acidify urine with IV ammonium chloride at 75 mg/kg qid, maximun dose 6 gm per day. Administer diazepam at hs. Using the IV method, the hyperkinetic state will be reversed within three to five minutes, and within twenty to forty minutes following oral medication. The use of phenothiazines and Haldol® have been specifically avoided due to their propensity to lower seizure threshold. The tricyclic antidepressants are avoided due to the danger of the appearance of true life-threatening arrhythmias in an already sensitized patient.

Withdrawal • The actual existence of physiologic dependency and a related cocaine abstinence syndrome is widely debated; yet a relatively consistent withdrawal syndrome is observed following cessation of chronic use. It consists of irritability, alternating anxiety and depression, boredom, perceptual problems, inability to concentrate, hypersomnia, fatigue, and intense drug craving. Medical detoxification should be accomplished in an inpatient medically supervised setting. Premature departures against medical advice (AMA's) occur most frequently at 24 and 96 hours. These are the times when drug craving is most intense, paranoid ideation increases, and intolerance to rigid treatment unit regulations surfaces. The science of "ART" should be employed. "A"—Acceptance as a caring understanding intermediary is essential. "R"—Reduction of stimuli; rest and reassurance will diminish most disruptive behavior. "T"—Talkdown technique with sincere concern and gentle manipulation will abort hostile actions. Initial restrictions should include no pass-phone-visitor privileges. After two days, daytime naps are not allowed. The night personnel often need extra staffing to handle the increased hallway traffic then. L-tryptophan, 2 gm ac tid, and 4 gm hs with a carbohydrate snack is an effective aid to sleep. Tyrosine is being studied as an adjunctive measure.

Vigorous structured physical activity plays an important role also. Diazepam appears to be the ideal sedative for the over-amped cocaine user. Oral dosage of 10 to 20 mg every 6 to 8 hours is quite effective.

Post-detoxification • Does cocaine addiction require a specific therapeutic program? This is an unsettled question. More often than not, the traditional 28 day inpatient alcoholism program is the only available resource. Such programs frequently do not want to handle cocaine abusers because they believe it is a completely different problem. While I feel it is overly simplistic to lump all addictions under the umbrella of "chemical dependency," the striking similarities between cocaine addiction and alcoholism merit treating both in similar fashion. Both are culturally accepted and while cocaine is illegal its use generally does not occur within the same milieu as the other illicit drugs, especially the narcotics. These considerations as well as that of polydrug abuse should be noted when structuring and tailoring a treatment plan specific for cocaine addiction. In the meantime, it appears that traditional inpatient alcoholism programs have the most to offer for the cocaine addict. Didactic education, individual and group counseling, cognitive restructuring based on reality therapy, family therapy, and ongoing participation in posttreatment self-help groups are essential ingredients of an effective treatment program.

Cocaine addiction is viewed by "addictionologists" as a primary disease of multifactorial etiology. The addiction is not merely a symptom of underlying psychopathology. This is a critical distinction. For therapy to be successful, treatment must focus on the toxic consequences of cocaine. The goal must be a cocaine-free recovery. To accomplish this, the treatment team helps the patient find positive and constructive alternatives to deal with the drug hunger, emphasizing that any attempt to return to the drug is a relapse. Once an addictive disease is established, one cannot return to any recreational use. Total abstinence is required.

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How the addict gets his prescription

Dale K. Lindberg, M.D.

ABSTRACT: At least 60% of the opiate addicts applying to a South Florida Drug Treatment Program are currently addicted to prescription drugs, especially Dilaudid (Hydromorphone). Through fourteen years of working with the opiate addict much information has been obtained on how addicts get these much desired prescriptions.

Dilaudids, 4 mg oral tablets, currently sell for up to $35.00 on the "street" or the drug black market.

This article intends to have an effect toward reducing prescriptions for narcotics and to help physicians be aware of some of the tricks addicts use to obtain these drugs.

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In my 14 years of dealing with opiate addicts in a methadone narcotic addiction treatment program, I have encountered many different tactics used by them to deceive physicians into writing narcotic prescriptions. Some of these ploys are discussed. If any of these patients are similar to some of the ones you have seen, beware. Chances are you are being "conned."

Federal law specifically forbids prescribing narcotics to maintain or treat a narcotic addiction or habit.[1] You may well forfeit your DEA registration as well as your Florida license to practice medicine if you violate this law.[2] Your good intentions may well force you to find another occupation, a high price to pay for being an easy mark.

Since about 60% of patients currently enrolling in methadone programs use Dilaudid (hydromorphone), I will use Dilaudid 4 mg as the example of the drug of choice. Other drugs used by addicts are Percodan (oxycodone and aspirin) dissolved and injected and Tussionex (hydrocodone and phenlytoloxamine) taken orally. Morphine sulfate and Demerol (meperidine) are not frequently encountered. Oral tablets of Dilaudid are dissolved and injected intravenously by most addicts.

Examples of ploys: "I just got this bad pain in my back on my right side about two hours ago and had some red blood in my urine just now. I've had these kidney stones on my right side for about 18 months. They analyzed one I passed, and they told me to watch my diet and not drink milk, eat cheese or other food with calcium. They did an IVP which showed the stones, but I had a bad reaction to the dye and they told me never to have another x-ray with iodine in it because I might die."

This patient seems to be in distress with moaning etc. and even with a pale face, perhaps, achieved by make-up. When asked for a urine specimen, he

will reluctantly provide one. Of course, it will be loaded with blood obtained by a surreptitious puncture of the scrotum, penis or finger tip. He will have read the "Merck Manual" and maybe even Harrison's "Practice of Medicine." Upon examination, he will provide the correct responses of right CVA pain to percussion and exhibit tenderness of the right flank. He will say that his former doctor up North has recently died or was an ER physician who cannot be identified. He will say that he was prescribed some "little yellow pain pills" to take whenever the pain "got bad — Diluene or Dilantin, or something like that." They tried Demerol and something else, but this was "the only one that worked."

When you mention other pain medicines, he may prompt you to say "dilaudid" by remembering that there is a "four" on it. Finally when you mention Dilaudid, he will exclaim, "That's the one," and he will tell you he only needs about 40 or 50 of them. When he has the pain, he has to use them frequently, and, since he doesn't want to bother you, maybe 100 would make it easier for you. The patient will be ever so grateful and will cheerfully pay your office fee and laboratory charges. He will return in four to six weeks, just as grateful. He will then tell you that he had a bad spell last night and used the last three tablets getting over the pain while soaking in a hot tub. These patients are very appreciative for all you have done to help them. They should be! One hundred tablets of 4 mg Dilaudid sells for $3,500 in small quantities or a full bottle of 100 tablets will bring $1,500 in the illegal drug market.

If you continue treating this patient by meeting his requests, you can be assured of a grateful patient and, soon, others just like him. The word passes quickly among the addict community as to where these prescriptions can be obtained easily.

Many addicts are very ingenious. This patient might bring in x-rays showing a definite opaque ureteral calculus even with the hospital name and the addict's name and date on it. Fifty dollars can buy one of these from a radiology technician who puts the addict's name on "one extra exposure." One patient had carved a piece of chicken bone to the size of a ureteral calculus which he would put on his abdomen at the correct spot in the event a plain film of the abdomen was ordered.

An elderly woman with severe osteoporotic kyphosis who requests "only two or three Dilaudids a day to keep going and get some enjoyment from life" might well persuade a compassionate physician to write her a prescription for 100 tablets every five or six weeks. He has no way of knowing that this woman goes to a dozen different physicians with the same story and the same results. She keeps excellent records on which doctor was seen, when, where the prescription was filled and when to return. One woman obtained enough Dilaudid in this way to provide for her needs and support her husband's addiction.

One patient enlisted the aid of an alcoholic "friend" who had scars from a radical neck dissection. He found this man after visiting many "wino bars" and told him how he could make "lots of money." He instructed this man in how to describe his pain and how Dilaudids relieved it. He took the scarred-up alcoholic to different doctors every day to attempt to obtain prescriptions for Dilaudid. He gave half the pills to his collaborator and then bought them back from him for $2 each. My patient lived well and maintained his addiction until the "wino" told him, "I've got enough money now and plenty to drink, and I don't need you anymore." My patient, unable to find another person with these qualifications, was forced to seek treatment for his addiction.

The amputee with "phantom pain," the paraplegic with muscle spasms, as well as those with a malodorous draining osteomyelitis, especially of the tibia, are other types of patients who use their medical conditions to convince the physician that "only Dilaudid will help." The obese addict, especially females, use a nonfunctioning gall bladder with symptomatic biliary colic to obtain Dilaudid. Others may use dental problems to "con" Dilaudid from susceptible physicians. Some will present with slow growing visible malignancies. One such patient who had a cancerous invasion of the maxillary sinus encroaching on the orbit became a wealthy man from the sale of the Dilaudid he obtained from many different physicians.

Many patients also use the "low back syndrome" as their ploy to obtain Dilaudid. Beware of the patient who complains of low back pain who says he needs Dilaudid in order to work and that his "doctor up North" prescribed it before. Back pain, limited bending and straight leg raising on physical examination can be easily faked. Lumbosacral spine films frequently show a variety of radiologic changes in asymptomatic people who may claim pain to try to obtain narcotics. Only a few patients hospitalized for back pain need Dilaudid and no one with these complaints should be treated with Dilaudid as an outpatient and never on a chronic long-term basis.

The addict may begin by telling you: "None of the drug programs can help me. They are all too far away. I've been through them all. None are any good. I just know you can help me with my problem, or You can help me lick this." Don't be fooled by these stories.

Doctors of Veterinary Medicine are also not immune to the ploys of the addict. One patient had some hound dogs that frequently got "chewed up" fighting with wild hogs. "Only Dilaudids helped the dogs the last time." This story resulted in a number

of prescriptions for Dilaudid by the veterinarian. This same person had an old dog with such severe arthritis that it "cried" when it walked. "We've had her so long, my mother doesn't want to put her out of her misery, and the only thing that has helped her has been Dilaudid — only two or three a day." This story obtained many prescriptions for the drug from sympathetic veterinarians.

Dentists are also victimized by addicts, especially oral surgeons. Complaints of severe toothache in badly decayed teeth lead to the request for "just enough to hold me until payday when I can come in and pay to get that tooth pulled." At the next visit, "My baby had to go to the pediatrician, so I couldn't afford to see you last week. I still owe him some, so it will be the payday after the next one until I can have it pulled, and meantime I need more Dilaudids." This continues until the dentist finally balks. Then they seek out another dentist. They may even have one tooth extracted and complain of postoperative pain as the excuse for more Dilaudid.

Another source of supply for the addict is stealing from a legitimate cancer patient's prescription. Always ask your patients how many they are taking, not the person who accompanies the patient, and who may be using the patient's Dilaudid. A patient who only takes three or four tablets a day does not need a prescription for 100 every week. One patient's friend, a surgeon, came to see him while he was slowly dying of cancer. He visited his friend at home every night and "didn't even charge for it." He was not the patient's physician. The nurses always left the room when the friendly surgeon came and no one suspected him of removing ampules of Dilaudid for his own use. This physician was later treated for his addiction.

Another patient told me of forging a prescription for a relative for a small quantity of Empirin #3 which she took to a local pharmacist. She told him that the prescription was for her uncle who had moved from "up North" with "cancer of the prostate, spreading all over." The forged prescription was "written" by a Miami urologist which would have required a toll call to confirm. She wrote for increasing amounts and then switched to Percodan which she could sell on the "street" for more money. She always talked with the pharmacist about her uncle and his problems. When the Percodan "didn't work," she switched to 4 mg Dilaudid tablets, also in increasing amounts and dosage schedules. She finally became too greedy, and the frequency and amounts of the prescriptions led the pharmacist to be concerned enough to call the doctor in Miami for verification which uncovered the ruse.

Some patients will take a prescription they have obtained, expertly duplicate it and present it at several pharmacies. Some will steal blank pads from an office and forge the prescriptions using another legitimate prescription as a guide. Some physicians think they keep their DEA number confidential by not imprinting it on their prescription pads and only writing it on prescriptions for controlled drugs. Some who think they can maintain confidentiality by having a pharmacist call them for this number will be surprised to learn how many unnecessary phone calls are made to their office for this information. A patient can readily obtain a receipt for his prescription from the pharmacist which would also reveal the physician's DEA number.

Many physicians, even the cautious ones, do not realize how they could innocently write two prescriptions which would show an addict how to expertly forge a Dilaudid prescription, and include models for each letter to be written. For example, a new patient says he recently moved from the "North," has epilepsy, and is being treated with Dilantin 100 mg and phenobarbital gr ¼. He used to take the combination pill of Dilantin with phenobarbital, but he would occasionally forget to take one and then would have a seizure. His physician told him to take the three Dilantins at one time at bedtime because they were the most important, and gave him a prescription for the ¼ grain (15 mg) phenobarbital to take three times a day before meals. Few physicians would hesitate before writing these two prescriptions for this patient.

Now, write down on a prescription pad these three prescriptions for "Joe Blow." Write: (1) cap. Dilantin 100 mg #C-100 Sig Take cap. iii at h.s. (2) Tab Phenobarbital gr ¼ (15 mg) #C-100 Sig Tab i tid ac. (Include DEA number for Phenobarbital.) (3) Tab Dilaudid 4 mg #C-100 Sig Tab i tid prn pain. Look at these closely. Look how "Dilantin" is similar to "Dilaudid." You have written the "Dilau;" the "d's," the "4," "take," the "mg," "tid," "for," your DEA number and your signature. Imagine how easily you could help a forger to make a prescription for Dilaudid which looks exactly like your writing.

There are also unscrupulous physicians who sell prescriptions for 100 Dilaudid 4 mg tablets for as much as $400. Some women have engaged in sexual activity with the physician and are paid with Dilaudid prescriptions. Other physicians have been known to satisfy gambling debts, extortion demands, or obtain money for cocaine by selling narcotic prescriptions.

Just as guilty are the pharmacists who knowingly fill forged prescriptions or who fill prescriptions from a "loose-writing" physician and charge inflated prices to the addict. I know of prescriptions filled at one pharmacy from a "loose-writing" physician which cost $67.50 for 30 tablets of Dilaudid 4 mg. A pharmacist may charge what he wishes but usual charges at a pharmacy in my area are about $31 for 100 tablets. Patients who forge prescriptions frequently tell me they pay the pharmacist $150 or $200 for 100 tablets on a forged prescription.

How can you help minimize being a supplier to the addict?

1. Always be very suspicious of anyone who asks for a prescription for a named narcotic, especially Dilaudid.

2. Always check the veins of both antecubital areas, arms, and hands for needle marks or scars from numerous recent and past injections.

3. Include "Telephone Confirmation Required on all Schedule II Drugs" in large print under your signature line on all prescriptions. A way to prevent duplication of prescriptions would be to have printed on all of them "must be written in blue ink" and write all your prescriptions with a blue pen. Blue ink duplicates as black which would reveal that this prescription was copied.

4. If a pharmacist calls you regarding a prescription that you did not write, you should assist in apprehending this person. Obtain the pharmacist's name, pharmacy name, address and telephone number. Tell the pharmacist to delay the patient while you call the police to tell them of this scheme.

Each of us must do our part if we are to curtail the use of prescription drugs by addicts.

References

1. Code of Federal Regulations: 21 CFR 1306.04(c), April 1, 1981.
2. Medical Practice Act (Florida Statutes) Chapter 458: 458..331(h)(g).

● Dr. Lindberg, 3650 N. 36th Avenue, Villa 68, Hollywood 33021.

AMA's response to the problem of prescription drug abuse

Joseph H. Skom, M.D.

Over 30 million Americans are currently misusing or abusing drugs. This year they will spend more than $70 billion to buy them . . . drugs are becoming a part of the American lifestyle.[1]

The gravity of this nation's problem with drug abuse is now being widely reported. What is generally not sufficiently understood, however, is the extent to which misuse and abuse of prescription pharmaceuticals contributes to the overall problem.

Nonetheless, the hazards involved in nonmedical use of prescription drugs are substantial. For example, data reported through the federal Drug Abuse Warning Network (DAWN) in 1982 show that prescription drugs were involved in about 60% of all drug-related emergency room visits and 70% of all drug-related deaths. While many of these drugs were channeled into nonmedical use through theft and diversion at the wholesale level or were illegally manufactured or imported, a significant amount reached "the street" through dispensing on prescription. Therefore, greater caution is warranted in prescribing and dispensing controlled substances.

In its 1981 report entitled "Drug Abuse Related to Prescribing Practices," the AMA Council on Scientific Affairs identified four categories of physicians whose prescribing practices lead to abuse of prescription drugs. Subsequent research has demonstrated that these classifications also may be applied to all types of professionals who prescribe or dispense controlled drugs.

Dishonest or "script" doctors prescribe not for medical indications but purely for profit. Often they are not only "mis-prescribers" but "mass prescribers." For example, in a recent pilot project sponsored by the Drug Enforcement Administration, the first 20 physicians convicted of willful misprescribing had, as a group, written scripts for 21 million dosage units of Schedule II drugs.

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Disabled doctors are physicians whose professional competence has been impaired by alcoholism, drug abuse or mental illness.

Dated doctors are those who have not kept pace with developments in pharmacology or drug therapy. They are poor prescribers, not because they intend to be, but because they lack information or understanding. They may be prescribing excessive amounts of drugs for unusually long periods of time, or prescribing types of drugs that are not indicated for the condition being treated, or prescribing drugs when another type of therapy is indicated.

Duped doctors, as the name implies, are physicians whose intentions are ethical, but who fall prey to the tactics of patients who are drug abusers or who wish to obtain drugs for sale to others.

Ethical, competent physicians also contribute to the problem of prescription drug abuse through careless prescription writing, poor control over blank prescription pads, and poor safeguarding of drug supplies.

Patients contribute to the problem in several ways.

Patient pressure — Fed by articles in the popular press that report (often prematurely or inaccurately) the alleged benefits of a variety of drugs, some patients demand those drugs almost as a right. Such pressures can be powerful and are not always successfully resisted. Also, the prescription has a strong symbolic value for some patients: because it may be the only tangible item a patient takes away from a visit to the physician, it comes to be seen as evidence that a caring relationship exists.

Excessive use of prescribed drugs — Patients may use psychoactive drugs in amounts larger than those prescribed so as to achieve intoxication or other mood changes, or may increase the dose as tolerance develops.

Visits to multiple physicians — Some patients with multiple complaints visit several physicians and receive prescriptions from each of them. Many of these patients (because of forgetfulness, reticence or deliberate deceit) fail to report all of the prescription and over-the-counter drugs they are using, even when directly questioned by the physician. As a result, neither the primary physician (if there is one) nor any of the other involved physicians is aware of the patient's total drug regimen.

Deception — Certain patients with chronic disabilities, chronic pain problems, psychological disturbances, and drug abuse problems become theatrically proficient at feigning illness. In the drug culture, this is known as "working" or "making a doctor." Ruses employed include physical signs such as self-inflicted bleeding, abscesses or skin lesions; description of the symptoms of renal colic, toothache or tic douloureux; or presentation of psychological complaints such as anxiety, insomnia, fatigue or depression. These tactics seem obvious when described but they can be employed very convincingly, especially in the midst of a busy medical office or emergency department.

Solutions • Measures to counteract prescription drug misuse, abuse and diversion can take several approaches including education, persuasion and legal control. Recognizing that physicians must have the greatest possible latitude in their use of drugs, the AMA has endorsed a series of general and specific guidelines issued in 1981 by the U.S. Drug Enforcement Administration to encourage "acceptable professional responses to the demands of the Controlled Substances Act." The general guidelines affirm that controlled substances do have legitimate clinical usefulness but that prescribing these drugs requires special caution because of their potential for abuse.

In the area of medical education on drug abuse, the AMA has made significant contributions. The 1970 monograph on "Drug Dependence" presented the best clinical information on drug abuse available at that time. Since then the volume of research on the etiology, pharmacology and sociology of drug abuse has expanded at a rapid rate. Unfortunately, so has the proportion of the population — youthful and adult — that is experimenting with illicit drugs or using them regularly. Indeed, physicians are seeing a growing number of patients whose medical and psychological problems are caused or complicated by drug abuse. At the same time, the scientific literature has become so rich and diverse as to require exhaustive and time-consuming study.

In response to this dilemma, the AMA has published a concise text for physicians that incorporates the latest research on, and clinical experience with, drug abuse. That 1981 physician's guide, "Drug Abuse," has been most favorably received.

In addition, the AMA is preparing to take a major step forward in providing medical information and education to physicians and health care institutions through use of telecommunications. In late 1982, AMA and the GTE Corporation unveiled a new nationwide electronic information system — the AMA Medical Information Network — which will be able to transmit clinical, educational and socioeconomic information to physicians and other health care professionals. When completed, it will be the largest and most extensive system of its kind ever developed.

The AMA network is designed to help physicians keep pace with today's exponential growth of medical information. The initial service includes four data bases: Drug Information (based on the fifth edition of "AMA Drug Evaluation"), Disease Information, Medical Procedure Coding and Nomenclature, and Socioeconomic Bibliographic Information.

Using the Drug Information data base, physicians will have immediate access to current information developed by experts on drug actions and interactions, prescribing indications and cautions.

The AMA also continues to publish its major reference work, "Drug Evaluations." This volume, now in its fifth edition, provides pharmacologic and comparative evaluations of more than 1,800 individual drug preparations under more than 5,000 trade names. The new edition features an entire chapter on the special problems inherent in prescribing controlled drugs and the need for patient education on appropriate use of all prescription medications.

To assist the physician in that educational process, the AMA has developed written instructions for patients on the most widely prescribed drugs. For the past decade, the medical community has agreed that patients need additional information about the drugs they take. Opinions have varied about the best method of supplying that information. The AMA has strongly supported the view that it is the physician's responsibility to impart this information at the time that a drug is being prescribed. Therefore, the AMA's new program, called Patient Medication Instructions, or PMIs — is being made available to physicians for use in their counseling with patients. Use of the PMIs should enhance the effectiveness of therapy, reduce the risk of improper drug use, decrease the incidence of preventable and serious adverse reactions, and help patients comply with instructions for proper use of prescription medications.

AMA also has addressed the interests of the larger public in its educational efforts. The AMA Health Education Program is developing a series of one-page information sheets to respond to the inquires most often received from the public. These information sheets will cover topics of broad public concern, including treatment resources for drug and alcohol problems, correct use of prescription medications, and how to communicate effectively with one's physician about prescription drug effects and reactions. Because this information can be compiled and published rapidly through a new data base, the information sheets can be updated as new knowledge becomes available and new sheets generated on additional topics as inquiries on those topics are received.

Activities such as these are being coordinated through an AMA Internal Staff Task Force on Prescription Drug Abuse created in 1982 to continue to develop Association and Federation initiatives to reduce the abuse of prescription drugs and improve physician's prescribing practices. The Task Force also supports AMA's cooperative efforts with other organizations in the public and private sectors, principally through the new national Informal Steering Committee on Prescription Drug Abuse.

Cooperative efforts • AMA convened the Steering Committee in November 1981 in response to a charge from the House of Delegates that called on AMA membership and staff to cooperate with all other interested organizations in developing effective programs to reduce prescription drug diversion and abuse.

Acting on that mandate, AMA invited more than 20 organizations — prescribers, dispensers, manufacturers, regulators and enforcement agencies — to send representatives to a meeting in November 1981, one year after the White House Conference on Prescription Drug Abuse. Those who came to that first meeting agreed to constitute themselves as the Informal Steering Committee on Prescription Drug Abuse with the idea that such a committee would serve as a fulcrum for coordinated national action on the problem.

The Steering Committee began its work by agreeing to:

- Foster the development of problem identification and resolution activities through cooperative, interdisciplinary programs at the state level.
- Develop methods to identify substandard prescribers and dispensers, to assess the causes of their problems, and to institute appropriate remedial measures.
- Promote better prescribing and dispensing practices on the part of all practitioners.
- Educate patients and the public in the proper use of prescription drugs.
- Engage the support of all concerned professionals and governmental organizations for cooperative programs to achieve these goals.

To achieve these broad goals, the committee established a series of ten specific program objectives.

First, the members agreed that they would continue to use the Steering Committee to arrive at agreements on the nature of the problem and what to do about it. This, of course, requires willingness to share ideas and information and a sustained commitment to support activities endorsed by the committee.

A second objective is to provide maximum support for a series of interdisciplinary conferences designed to initiate common understanding of problems and solutions at the state level. To date, eight states have participated in such conferences with 11 more now in the planning stages for 1984.

Third, the committee urged the formation, in each state, of an interdisciplinary task force to coordinate ongoing problem identification, goal-setting, planning and action. Task forces of this type have been established in six states and more are in the organizing stage.

A fourth objective is to establish a financial clearinghouse to match the resource needs of state program planners with available sources of support.

This clearinghouse, although it functions quite informally, already has yielded generous support from several pharmaceutical manufacturers for state conferences and other worthwhile programs.

Fifth, the committee endorsed the development of professional education programs for prescribers and dispensers to raise their awareness of prescription drug abuse and help them identify and resist the tactics of "professional patients" and other drug abusers. Packaged programs consisting of a videocassette, text, and instructor's guide are now being prepared for physicians and pharmacists and will be available to state and county professional associations, licensing boards, and hospital staffs early in 1984. Similar programs for other health professionals are in the early planning stages.

A sixth objective is to develop a data analysis model for use by states in identifying sources of diversion. This model — called PADS (Prescription Abuse Data Synthesis) — demonstrates how to use statistical data already available from federal, state and local agencies to determine the extent of the drug diversion problem within a state, the drugs involved, and the individual or institutional sources from which those drugs are being diverted to nonmedical use. PADS is based on the concept that efforts to eliminate sources of diversion will be more effective than strategies that focus solely on particular drugs. The model has been developed by a team of experts from state drug abuse agencies and the federal Drug Enforcement Administration with staff assistance and financial support from the AMA.

The PADS model was approved by the Steering Committee and other consultants in February 1983 and now is undergoing a rigorous field test in Florida and four other states. At the conclusion of the test (early 1984), PADS will be offered to officials in all other states with the technical assistance needed to implement it.

Seventh, the committee decided to study legislative issues that affect regulatory, enforcement and intervention activities to reduce drug diversion. A survey of all 50 states has just been completed and model legislation will be drafted to meet any identified needs.

An eighth objective is to explore the feasibility of "clearinghouse" type functions for use by professional licensing boards in exchanging information about disciplinary actions against practitioners. Without a method of sharing this information, it is all too easy for practitioners whose licenses have been suspended or revoked in one state simply to relocate in a different jurisdiction. Obviously, there are some sensitive issues to deal with here such as confidentiality and protection of individual rights. Nonetheless, the concept has widespread support. The National Association of Boards of Pharmacy and the National Council of State Boards of Nursing recently adopted clearinghouse programs while the Federation of State Medical Boards and several other national associations of licensure boards either already have or are considering such programs.

Ninth, the committee resolved to study the effects of diversion control methods most widely in use: peer review, controlled substances boards, triplicate prescription programs, and diversion investigation units. This comparative evaluation will assess costs, impact on drug distribution and consumption, effect on drug-related morbidity and mortality, and attitudes of professionals and the public. A protocol for the research is now being refined by a work group of the Steering Committee and completion of most of the component studies is scheduled for 1984. The research results will be shared with professional associations, government officials, and all other interested parties.

The tenth and final objective is to improve the ability of physicians and other health professionals to diagnose and treat (or appropriately refer) patients who are dependent on drugs and alcohol. This objective recognizes the fact that prescription drug abuse is not the whole drug abuse problem. Young people constantly high on marijuana or cocaine are a drug abuse problem. Drinking drivers who kill and maim on our highways are a drug abuse problem. The three- or four-martini lunch is a drug abuse problem. These are issues that demand the expert attention of physicians and other professionals. Whether or not prescription drug abuse is in the picture is a complicating factor, although the linkages are frequent and inevitable, as when the quality of heroin on "the street" declines to a point at which addicts seek the opiates on pharmacy shelves.

A corollary is that we must help physicians and others avoid initiating or sustaining drug abuse and dependence through injudicious prescribing and dispensing. While our priorities are first to weed out the "script docs," then to rehabilitate those who are disabled and educate those who are duped, we know that some form of ongoing education is appropriate for all practitioners. The rapidly changing nature of drug abuse guarantees that even the best professional training will not provide sufficient up-to-date information over the course of a medical or pharmacy career.

This, then, is our program for 1984 as it was for 1983. Granted, it is an ambitious undertaking. Neither the Steering Committee nor the AMA has all the answers; in fact, we are still learning how to ask the right questions. Nonetheless, we do know that concerned professionals working together for the good of our patients and the public can find effective solutions.

Reference

1. A Service Delivery Assessment of Drug Abuse, Office of Service Delivery Assessment, Office of the Inspector General, Department of Health and Human Services, Washington, D.C., August 1982, p.1.

- For further information about AMA and Steering Committee prescription drug abuse programs contact Bonnie B. Wilford, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.

Drug abuse prevention: what the AMA Auxiliary has to offer

Gillian Bolling

ABSTRACT: The American Medical Association Auxiliary is a leader in the movement to improve the quality of life and health, and therefore is actively involved in substance abuse prevention. At the state and county levels, AMA Auxiliary members participate in education, support, and prevention programs to help counteract the spread of drug abuse.

AMA Auxiliary services featuring information on drug abuse include the Project Bank, a clearinghouse of data on community service programs developed by local auxiliaries across the country; the People Bank, a listing of auxiliary members offering their expertise as speakers or resource persons; and various informative health care publications dealing with drug abuse. The AMA Auxiliary is also proud of its work in coalition with other organizations which fight drug abuse.

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As a leader in the movement to improve the quality of life and health, the American Medical Association Auxiliary is very concerned with substance abuse prevention. And the Auxiliary has translated this concern into action.

At the state and county levels, auxilians participate in programs that bring health care to every community. These programs are shared through the AMA Auxiliary's Project Bank, a clearinghouse of information on community service programs developed by local auxiliaries. Many types of health and welfare programs are represented with substance abuse being one of the largest categories.

Among substances abused, perhaps the most frightening to parents and community members are drugs. The American Medical Association defines drug abuse as "use of a psychoactive substance in a way that impairs the functioning of the person taking it or poses a threat to the health and welfare of others."

Project Bank entries offer many approaches to counteracting the threat of drug abuse. These include: sponsoring a high school essay contest on drug abuse; presenting a city-wide seminar on the topic and disseminating drug abuse materials to teachers; holding a panel discussion with a physician, a physician's spouse, and three former drug abusers to inform auxilians about chemical dependency; showing a film about drugs to elementary students; and helping establish school policy and procedures for counseling, education, and disciplinary action for drug abuse.

In addition to Project Bank, the AMA Auxiliary offers the People Bank. It is a clearinghouse of members offering their expertise to other auxiliaries as speakers or resource persons. A speaker addresses an audience on topics in a specific area and a resource person consults on projects, programs, or a special

interest area. Drug abuse is just one of the areas of expertise offered by People Bank participants. Also included are other topics such as alcoholism and the impaired physician.

Members of the national Health Projects Committee are also available for help in developing program ideas. The 1983-84 Health Projects Committee had each member focus on a specific area of concern with one member assigned exclusively to substance abuse prevention. Through national representative visits, members of this Committee can be requested to speak at or consult with particular auxiliaries.

Through its nationwide Shape Up for Life program, the AMA Auxiliary offers many informative health care brochures. Two specifically deal with drug abuse, "Drug Use and Abuse" giving information on drug categories, signs and symptoms, and solutions, and "Managing Stress" offering alternatives to substituting drugs for stress management.

"Drugs of Abuse" is the title of one of ten package programs on different health topics. Package programs give information and suggestions for community projects.

In service to the health care of the medical family, the AMA Auxiliary has the booklet, "The Impaired Physician." It includes information on support programs, educational programs, and prevention programs to help families of physicians affected by emotional disorders, alcoholism, or drug dependence. A listing of Project Bank entries on the topic is also included.

In an ongoing effort to educate the membership, FACETS magazine features frequent articles about substance abuse. FACETS, available as a benefit of AMA Auxiliary membership, recently had a feature story on preventing drug abuse among teens.

The Publications and Audiovisual Catalog lists, in addition to publications, videocassettes and audiocassettes available from the AMA Auxiliary. Currently offered is a videocassette on the impaired physician and audiocassettes on substance abuse, marijuana and children, prescription drug abuse, and drug abuse prevention.

The AMA Auxiliary encourages forming coalitions with other organizations which fight drug abuse. The Auxiliary has worked with, among others, the National Institute on Drug Abuse and PRIDE (Parent Resource Institute for Drug Education.) These organizations supply information for publications or make their materials available to members.

Whether serving the needs of members or community leaders, the AMA Auxiliary supplies important information on drug abuse. Its programs focus on education, support, and prevention in helping to counteract the spread of drug abuse.

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Addiction and the other illness

Dolores A. Morgan, M.D.; John C. Eustace, M.D., and Jules Trop, M.D.

ABSTRACT: It is now recognized that addiction is a multi-factorial illness involving more than just the chemical substance itself. Treatment of this illness must address these other problems.

One of the major factors involved in the total illness is related to the sexual behavior of the patient. The authors refer to this phenomenon as "the other illness." Case histories are presented to demonstrate the effect of chemical substances on the sexual behavior of affected patients and their peers. Emphasis is placed upon the importance of the recognition of sexual problems and the need for their treatment as part of the comprehensive approach to the ultimate goal of physical, emotional and spiritual rehabilitation of the suffering patient.

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The use of chemicals for recreational and/or coping purposes in 20th century society is presenting new challenges to the medical profession. Terms such as "recreational drugs," "responsible drinking" and "sexual freedom" are creating confusion in the minds of young and old alike. This confusion when coupled with chemical use may lead to devastating psychological and sometimes painful or potentially dangerous physical conditions.

Changing societal values and priorities may be responsible for positive and negative long-term effects in individuals and families. There is little doubt that our value systems or lack of them during our youth cause us to behave in certain characteristic ways. If we are raised in a home where drinking, drug use and sexual promiscuity are tolerated or where role models demonstrate these behaviors, the results will differ from a home in which the values are spirituality, self-respect and responsibility for one's behavior. Families and individual family members must begin early to communicate and demonstrate the values and priorities they hope to see carried out by their children and grandchildren. The increasing prevalance of drug use and abuse in all generations is also affecting the value system and moral code development of the individual.

It is well known that certain physical changes relating to sexuality occur during preadolescence. Secondary sex characteristics in both sexes are determined by pituitary function and related hormonal activities. It is further known that sexual identity may be determined by a number of factors during childhood and adolescence. These factors include home and societal environment, parent-child relationships, sexual experiences, and parental attitudes about sex.

Genetic factors may play a role as well as environmental influences in the male or female behavior. Many attitudes have changed in society about sex including a drive to eliminate sex discrimination and promote a unisex approach in hair styles, clothing, employment opportunities and many other areas. There have been societal pressures to change attitudes about homosexuality, community sex, and abortions. There seems, however, to be little attention given to the psychological consequences that these changes may create in our youth or even the middle aged or elderly individuals in our population.

This paper is intended to identify some of the sexually related consequences seen in an addiction treatment program as a result of drug abuse, including alcohol, and the behavior resulting from changing social mores. We have been impressed with "the other illness" as it appears among our addicted population. We have been especially impressed with the failure rate of the treatment program in individuals who do not address their feelings relative to sexual behavior and/or consequences of such behavior while abusing drugs. Since we have become increasingly aware of the effects that abused drugs may have on changing the individual's sexual drive or interfering with normal sexual functioning, there is a responsibility to transmit this information to individuals abusing drugs and to the medical care system in general.

Case reports • We present case examples of individuals to illustrate some of our observations related to drugs and sexual consequences.

Case 1. — Failure to Conceive. A couple had been married for 11 years, the husband is 32, the wife 31. Both have been daily marijuana users for at least 10 years. They have taken no precautions to avoid pregnancy and, in fact, were very desirous of having a child. The husband received treatment for his addiction. His wife became actively involved in the treatment and made a commitment to stop smoking marijuana. Within six months after they stopped using drugs, she became pregnant.

Much research has shown that marijuana decreases the testosterone level in males, decreases viable sperm count and causes anovulation in females. Research performed on rhesus monkeys shows that these effects are due to hormonal changes. We willingly accept rhesus monkey studies relating to other types of research but have difficulty accepting research on this same species relating to effects of marijuana. The reason is society's attitude about drugs and its need to deny their inherent dangers.

Case 2. — Abortions. A 21-year-old Jewish female from an upper middle class family entered into treatment for addiction in 1978. She was obese with unattractive bleached blonde hair and her skin was blemished. History revealed that she had her first drink at age seven years beginning with wine on holidays. She started to drink regularly on weekends by age 16-17. She admitted to using and experimenting with various drugs since age 14. Initially she started with "pot," approximately three joints per week, but became a heavier user during college, nearly nightly. She had taken Quaaludes on some weekends for the past five years and used Valium for about one year in increasing doses, initially 5 mg twice a day and proceeded to 10 mg four times a day. She did "speed" for 18 months in 1975. She reported having three abortions, the first in 1971 in New York after a four to five month pregnancy and the second and third in 1974-75 in Miami. She had never married but had been involved with at least four men. She shared her experiences and feelings about them during treatment. This cleansing allowed her to take the first step on the road to an improved self-esteem.

Case 3. — Male prostitution. A 20-year-old male from a middle class Italian family came into treatment for a polydrug abuse problem. During the summer of 1975 he met a young woman in her 20s who was just out of law school, he was then 13 years old. They became emotionally involved. Because he had a weight problem, she took him to a "weight doctor" who put him on Dexedrine. After he lost 30 pounds, she bought him new clothes which he kept at her apartment. In addition to diet pills, alcohol use became a regular occurrence. At age 15, "pot" and Seconal were added to his drug experience. Drugs helped his sexual life with the older woman but he never felt totally satisfied. At 16 years he started to use cocaine and also to have homosexual relations. During the winter of 1981-82 he became a hustler and began carrying a beeper. To quote him, "My sexuality was confusing the hell out of me." By the time he was 20 years old, he was being supported financially by another older woman and at the same time was having a relationship with a young man, and became "a coke whore." He and two young male friends worked for an escort service and also dealt in cocaine. One of his friends was shot to death when a cocaine deal went bad. The other was found dead from an overdose of intravenous Seconal but the patient never "shot up" with drugs. The release he experienced from sharing his experiences, his feelings and accepting the consequences of his behavior during group therapy resulted in personal growth and a new acceptance of himself.

Case 4. — Homosexual behavior. A 26-year-old male from an upper class family sought treatment because he was both snorting and freebasing cocaine, about one-half ounce four days a week. He required a half quart of gin to "come down off the coke." He began drinking by age 16 and started with marijuana when 17 years old. From 17-19 years he ran a gamut of different drugs including PCP and Quaaludes. By age 19 he was using only cocaine and alcohol. He was too paranoid to participate in group therapy but when we were finally able to get him to discuss his problems on an individual basis he surfaced his guilt and shame because he had experienced "abnormal" sexual behavior while using drugs. When pushed to define his "abnormal" behavior, he described sexual acts with other young men and stated he felt sick to his stomach just talking about it. This sharing resulted in his ability to see how the drug and his behavior resulted in "the other illness;" he was able to forgive himself and cease abusing drugs.

Case 5. — Lesbianism. A 50-year-old self-professed lesbian was admitted for an alcohol problem. She had begun drinking at age 33 and started daily drinking at age 43, one-fourth to one-third of a bottle each day. History revealed that she had been forced to have fellatio with her father

when she was four years old. She had been married for only two weeks when her husband was killed in a plane crash. She then had a long-time sexual relationship with a woman who died during the time the patient was in treatment. She was looking for another female with whom to establish herself because she had decided she could accept her lesbianism and did not need to drink to do so. Her anger at her father and other men was acknowledged during therapy, and she was referred for additional psychological help.

Case 6. — Syphilis. A 32-year-old divorced female school teacher was admitted for treatment of chemical dependency. She started smoking marijuana in college and began using Quaaludes at 27 years of age. Her drugs became more important than her marriage which subsequently ended in divorce. For five years she had been using Quaaludes, 10 to 15 capsules per week, and smoked an ounce of marijuana each week. Laboratory values on admission showed an RPR titer of 1:1024 and a positive FTA. In view of the extremely high titer, a spinal tap was done which revealed CSF glucose 53, total protein 29 and a reactive VDRL. An infectious disease consultant diagnosed central nervous system lues which was treated with aqueous penicillin 2 million units every 4 hours for 10 days. She was able to accept this serious illness as a consequence of her drug use and resultant sexual promiscuity.

Case 7. — Abortion. A 27-year-old professional woman was admitted because of a problem with drugs which had been discovered by her hospital associates. She began using Demerol by injection approximately one year prior to admission following a four-year relationship with a married man, pregnancy and an abortion. She described herself as "honest, moral, with a good sense of values, but lately feeling unhappy, guilty, mixed up and lonely." She identified and verbalized feelings of anger, hurt and despair, dealt with the destructive and hopeless relationship she had been involved in and expressed grief related to the abortion.

Case 8. — Rape. A 39-year-old married man was referred to the Addiction Treatment Program because of an alcohol problem. He took his first drink at age 16 and started to drink daily in his later teens. He had a history of blackouts secondary to alcohol abuse and in 1980 was arrested for rape. He stated he was in an alcoholic blackout and not at all aware of this act. He was married and had three children ages 13, nine and five years. He was subsequently convicted and committed to a state penitentiary. Prior to entering treatment he attempted suicide because of despondency. While in treatment he dealt with his feelings about his crime and openly discussed it with the group. In prison he became actively involved in Alcoholics Anonymous and later wrote us a letter to say it was hard for him to admit what he had done because he was so ashamed but he felt a great relief after discussing it in group therapy.

Case 9. — Peyronie's Disease. The patient is a 32-year-old male divorced health care professional who was admitted for treatment of cocaine addiction. Physical examination revealed a nasal septal perforation and painfully tender, nodular penis. A urological consultant diagnosed Peyronie's disease. History revealed that he was reared in a family with staunch traditional moral values. As his cocaine abuse escalated, he became involved in extramarital affairs and divorce ensued. Shortly thereafter he was performing "sexual gymnastics" and anatomically bizarre coital positions usually in orgy-like settings with other cocaine abusers. He acknowledged that the cocaine completely altered his moral character, stimulated sexual fantasies which he attempted to act out and indirectly caused the traumatic penile lesion which may be irreversible.

Discussion • We believe that these case histories represent typical examples of the potentially devastating and permanent effects of chemicals including alcohol and other drugs on addicted patients' lives. The precise etiology of severe sexual dysfunction associated with the addictive illness is not known. It is well accepted that sexual behaviors are learned as well as resulting from environmental, social, moral and possibly genetic influences. Since the sex centers of the brain depend upon a delicate balance of neurotransmitters, most likely in the serotonin and dopamine family, for their proper function, it is likely that the direct effect of exogenous chemicals such as alcohol and other drugs as well as their metabolites may then act as false neurotransmitters. They then upset this very important homeostatic balance. The result is loss of control over inhibitory centers which normally would not allow sexual behavior patterns outside an individual's learned set of moral and social values. These cases further suggest the power of chemicals in the brain and their potentially devastating effects. It is likely that, as the addictive illness progresses, the false neurotransmitters or altered receptors within the brain may lead to loss of libido and of sexual potency. This change from the hightened activity to the loss of ability to perform sexually (the direct effect of chronic use of drugs upon the nervous system) may result in increasingly bizarre activities (community sex, bisexual activity, rampant promiscuity and incestuous behavior). This deviant sexual activity may then result in guilt and more extensive chemical use to cope with the guilt. Thus a cyclic pattern develops consisting of drugs — sexual dysfunction — more drugs and ultimate total devastation of the individual's life and the lives of those who love him.

As most of our cases illustrate, an individual from a middle class family with standard upbringing may, while under the influence of chemicals, completely lose control of his moral values. Thereby he suffers a sexually related consequence, either physical or emotional. Our experience has further indicated that the "other illness" results in a significant change in the emotional and physical being of the patient. It is likely that the chemically dependent person will return to his or her pattern of drug abuse if the sexual problems are not discovered and addressed. A careful, gently probing psychosexual history is, therefore, and important part of the overall evaluation of the chemically dependent patient. Group therapy, individual counseling and, when required, specialists in the field of human sexuality are helpful in resolving these issues. Complete and thorough physical and laboratory evaluations are equally as important and

mandatory in the treatment of the addicted patient. The emotional and psychological pain of guilt, shame and remorse, if not treated by counseling and support group mechanisms, is likely to result in the affected patient's return to self-medication by use of alcohol and/or other substances.

Conclusion • Clinical experience has shown that addicted patients usually have a sexual problem or its effect present in their lives as a result of their chemical use. This phenomenon we have labeled "the other illness." The precise mechanism for this fact is not known, but drug altered neurotransmitters and their effects on selective brain receptors may be implicated.

It is our experience that if sexual problems are not recognized and addressed during treatment of addicted patients, the relapse rate is likely to be 100%. This discussion and these case histories may be helpful to practitioners and specialists as they assess veneral disease, marital problems, family and sexual dysfunction. Recognition of "the other illness" may be a clue to concomitant chemical dependency and vice versa.

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Medical professionals helping with the drunk driving problem

James J. Onder, Ph.D.

ABSTRACT: Our country has one of the safest highway systems in the world, however, the number of accidents in which alcohol is involved is one of the highest, causing the death of approximately 25,000 persons each year. These accidents are the leading cause of death among teenagers.

The medical professional can help by educating patients with drinking problems who may be unfit drivers, mobilizing colleagues to reach out to the community leadership, preparing articles and making presentations at conferences on the relationship of alcohol to driving, initiating resolutions for law changes and encouraging enforcement of laws and policies in the community, encouraging colleagues to become active citizens in their community, and initiating more alcoholism topics in the medical curriculum.

It will take concerted effort by the health care professional, other countermeasure groups and volunteers to reduce alcohol-related crashes on our highways.

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The United States has one of the safest highway systems in the world. Design characteristics, guard rails, markings and signs are among the best and contribute substantially to the relatively low number of crashes. There are few fatalities for every 100 million miles. The portion of accidents, however, involving alcohol is one of the highest in the world.

At least 55% of all highway deaths involve the irresponsible use of alcohol. Over the past ten years, 250,000 Americans have lost their lives in alcohol-related crashes. Conservative estimates place the annual economic loss as high as $24 billion for disabling injuries, lost work days, worker compensation claims, productivity, and property damage. There is, of course, no way to measure the loss of human lives.

The average drunk driver killed on our highways has a .20 blood alcohol concentration (BAC) level, double that for presumed intoxication in most states, To reach this level, a 180 pound man, for example, would have to have approximately 15 drinks of 86 proof liquor or 11 beers within a four hour period.

Our young adult drinking drivers are overrepresented in the statistics. Almost 60% of fatally injured teenage drivers are found to have alcohol in their blood systems prior to the crash, with 43% at legally intoxicating levels. In fact, the Surgeon General reports that life expectancy has improved in the United States over the past 75 years for every age group except one. The exception is the 15-24 year old whose death rate is higher today than it was 20 years ago.

The drunk driving problem is so pervasive it is considered the most often committed violent crime in the nation. It has been the leading cause of death in the military for the past several years, and many

detoxification and treatment organizations report it is the number one reason people begin the alcohol education and rehabilitation process.

An even more pervasive problem is the social acceptability of intoxication and drunk driving. The person who drinks at a party or commercial establishment will most likely be a driver or passenger. Americans are uncomfortable with those who drink to excess but by and large do not feel it is their responsibility — or even their right — to prevent intoxication among their friends. In fact Americans have a long tradition of laughing at "drunks" in the movies and in their own social circles. In the minds of many, this constitutes societal approval of drunkenness. The combination of social acceptance of intoxication and omnipresence of the individual passenger car adds up to the overly high social acceptability of drunk driving.

New hope of solution • In the past two years, society has reacted to the drunk driving problem in ways it had not in the past. For the first time, the public is demanding solutions. No one is in favor of drunk driving nor drunk drivers. Within the last year, 40 states enacted improved legislation and 41 established task forces or commissions to examine the problem, identify system deficiencies, and recommend solutions. This all began when a number of citizen action groups brought the problem of alcohol-related tragedies to the attention of the public and to officials at the local, state, and federal levels. The Department of Transportation, National Highway Traffic Safety Administration and the Presidental Commission on Drunk Driving continue to help research, coordinate, and fund state and local programs.

Media have become actively involved in supporting and publicizing improvements in the system. State and county legislators, enforcement officials, prosecutors, and judges, civic groups, driver license bureaus, alcohol educational treatment centers and medical community professionals have responded to society's demands by enacting more effective legislation, apprehending and correcting more offenders and starting new programs. The work has begun.

One of the main components of the systems approach to solving the drunk driving problem is the health science professional.

What the medical profession can do • In trying to respond to the problem of drunk driving, the concerned medical professional may feel bewildered. Physicians do not commonly deal with government agencies, corporations, state legislatures, Congress, and the media. Nor do they usually take individual action or mobilize to initiate prevention programs for highway injuries. But drunk driving is different. It is a major medical problem and the leading cause of death for people under 25. It exacts an enormous toll on individuals, families, communities, and the health care system.

The ideas that follow will have to be adapted to the particular circumstances. Since the medical profession is so diverse it is difficult to offer a blueprint for action. But by sizing up the "terrain," physicians should be able to identify pressure points as skillfully as they might locate an internal disorder.

Educating patients • Direct contact is probably one of the most effective kinds of persuasion. Medical professionals are in unique positions as trusted authorities who have frequent personal contact with large numbers of patients with drinking problems. Physical examinations present an excellent opportunity to talk about the relationship of alcohol and driving along with disease and health issues. This would include:

- Identifying the damaging physiological effects that alcohol has on vision, reaction time, attitude, false sense of confidence, sensory changes, depth perception, night blindness (recovery time is even less when drinking), "deep muscle sense" (the body's ability to feel changes in direction and speed), judgment, diminished alertness, ability to distinquish between signs and signals, ability to process complex reactions simultaneously, and the overall effect on a person's ability to drive.
- Discussing the effects of alcohol on the ability to drive when the driver is on prescribed medication.
- Showing the value of wearing safety belts and strapping children into safety seats as the best defense against the drinking driver.
- Dispelling common "myths" about eliminating the effects of alcoholic beverages, e.g., fresh air, hard work, coffee, showers, home remedies, running and walking around.
- Discussing blood alcohol concentration (BAC) and how it may vary among individuals.

During examination, the physician should discuss matters related to the patient's drinking and those classifying him as an unfit driver. If his chances of causing a serious crash increase the longer he continues drinking, the physician must decide whether to call attention to the patient, family, and/or authorities or restrict attention to the medical treatment of his condition. Laws and malpractice insurance, however, should be discussed with an attorney to see how far the law and its interpretation have moved from the once inviolate concept of doctor-patient confidentiality toward a growing regard for the public good.

Normally, physicians are on safe ground if: the intentions are discussed with the patient and he agrees to reporting the facts of his impairment; examination is being done for a driver's license, automobile insurance, or claims investigation; if the physician is doing a preemployment physical where driving is a job prerequisite; giving medical care following an auto crash, particularly emergency care; or practicing in a state or on a military installation where physicians are required by law to report specific medical conditions to the motor vehicle agency.

Negligence, of course, raises other malpractice issues. Physicians should also discuss this with their attorney. In general, physicians should provide the standard of care normally expected. They should not fail to perform an examination that would reveal a driving impairment. They should not fail to inform the patient of an alcohol problem that poses a high driving risk. They should not fail to warn the patient of the hazard inherent in a prescribed drug — perhaps the most common basis for negligence.

Physicians should display drunk driving literature such as posters, brochures, and articles in waiting rooms. Some physicians and clinics are starting to use self-contained film projectors. Why not include a repertoire of films or public service announcements on the issue?

Mobilizing the medical profession • Before the medical profession can start to reach out to others — the community, automakers, government, and the media — it must alert its own members to the issues and the need to be active. Since it is difficult for physicians to accomplish this on their own, support is needed from hospitals, medical societies and associations, charitable groups, and similar organizations.

Needed are standing committees within medical associations, injury and accident prevention programs within hospitals and medical centers, and staff to generate information and pursue initiatives on a day-to-day basis. Perhaps a full-time staff person is critical to produce and distribute new information that can be useful in legislative efforts and public education campaigns. The medical profession or medical group needs to speak with a united voice and provide ongoing expertise and guidance. This multiplies the profession's influence and lends continuity to its efforts.

Health professionals should speak at conferences and conventions. A relatively easy way to let other members of your medical specialty know about the health hazards of traffic accidents is through special purpose exhibits. A traffic safety exhibit highlighting related research findings could be a great source for disseminating information. It could also provide the basis for a professional article of further research. Several posters, displays, publications, and films are available from the Department of Transportation, National Highway Traffic Safety Administration, National Institute of Alcohol Abuse and Addiction, National Council on Alcoholism, and other national and state organizations.

Physicians should prepare articles for medical bulletins and newsletters. Few medical professionals develop an awareness of the injury consequences of crashes unless these are highlighted in medical bulletins, newsletters, and other periodicals. The editors of bulletins should solicit more articles on how alcohol-related crashes affect patients in a particular specialty. Perhaps a bulletin could donate space for a "public service message" telling physicians where they may obtain materials on occupant restraints to give to patients. Preventive steps could be given visibility in a bulletin. Newsletters and publications with limited circulation can alert their readers with items of timely, local interest. When possible, articles should reflect solutions at the community level.

Drunk driving issues could be included in medical curricula. If physicians are to approach motor vehicle injury with full awareness of its causes and potential solutions, they need to know more about "traffic medicine." As related to drunk driving issues, medical schools should develop a curriculum on the effects of alcohol and injury prevention. Some courses could be available to local countermeasure groups seeking more knowledge about the disease aspects of alcoholism. How often are grand rounds done on these issues?

To keep physicians abreast of new developments in the field, state and national professional societies should offer traffic medicine courses as part of required continuing medical education. Members of drunk driver countermeasure organizations could be permitted to attend. State and specialty licensing boards can register their concern that physicians know about injury prevention by including appropriate questions on licensing examinations. As long as traffic injury is given short shrift in medical education and licensing, those who practice medicine will have only a limited understanding of the problems involved and the solutions at hand.

One way to alert members of a medical specialty to traffic safety problems is to introduce a resolution at the annual convention calling for support of drunk driving issues.

A group of pediatricians introduced a resolution on child passenger safety to the 1979 convention of the American Academy of Pediatrics calling on the membership to "establish a major national initiative for child transportation safety analogous to the immunization initiatives" of the past. The resolution was approved unanimously and the result was

the "First Ride . . . A Safe Ride" program which seeks to ensure that every newborn baby leaves the hospital in a safe child restraint device.

Perhaps the time has come for resolutions on drunk driving. The American Medical Association Auxiliary has declared drunk driving as one of its topics of emphasis in 1984.

A resolution can also put a profession on record in support of pending legislation.

If injury prevention is to have a broad impact, other health professionals within a hospital, medical center or industry need to understand why it is important. Physicians need to teach and motivate hospital personnel to reinforce the drunk driving safety message in dealings with patients. Films could be shown to physicians and other staff and articles published in the in-house newspaper announcing the special attention given to alcohol-related crash protection. For those with the resources, workshops could be held to galvanize hospital staff and provide the opportunity for community leaders to learn more about the issues.

Activating your community • Medical professionals have an expertise that needs to be shared outside the examining room and hospital. With their strong ties to the community, either personally or through their medical affiliations, physicians have a stature that makes them natural advocates for auto safety. The points of access and influence with the community are many.

Medical professionals as individuals can have an impact simply by being active citizens. When you spot a traffic hazard, notify the appropriate local official. If a state drunk driving law is too lenient or a new law is being considered, offer elected representatives your support. If the local newspaper fails to tell the story behind a crash, ask the editor why. Write letters to the editor to make a public issue out of safety concern. Write letters on drunk driving to the political leadership. Talk about drunk driving issues to friends and neighbors. The word-of-mouth influence of physicians can be considerable.

Activating a community to address drunk driving issues means making people aware of the problem. The personal testimony of medical professionals who deal with crash victims can make quite an impression with audiences. Community service groups like the Kiwanis or Rotary Clubs offer a perfect opportunity to reach influential civic leaders and perhaps enlist their support. Another receptive audience is school children who are just learning the attitudes and habits that will stay with them throughout their lives. Teaching them about alcohol and driving can have special long-term effects and can also indirectly affect their parents' habits (similar to the impact of children asking their parents not to smoke). Serve on or form your own speaker's bureau.

Work with community groups on a safety program. A hospital or medical society that sponsors a drunk driving program can have the effect of a pebble in a pond sending out ripples that touch many different parts of a community. With their community connections and medical expertise, a group of physicians, hospital or medical society can serve as a catalyst in the community. The PTA, state motor clubs, state chapters of the National Safety Council, National Association of Women Highway Safety Leaders, Junior Chamber of Commerce, League of Women Voters, and other service organizations are likely collaborators in a safety project of this level. Indeed, many potential volunteers may sit on the board of directors of a hospital or medical center. Directors are often influential community leaders who, beyond their personal support, may be able to enlist the support of banks, newspaper publishers, radio and television stations, local utilities, and corporations. Some physicians have served on the board of drunk driving citizen activist groups.

Another linkage medical professionals in hospitals have to their community is the volunteer hospital auxiliary groups. These volunteers are typically eager to work on worthwhile projects. Moreover, their participation guarantees a word-of-mouth campaign which enhances the visibility of a drunk driving campaign and attracts new volunteers.

What should a good public information and education program consist of and how should it be conducted? Much depends on the resources of your community and, indeed, the special safety problem it may have. But any effective program could involve as many segments of the community as possible. It should focus energies around a specific drunk driving issue and use specific steps to change people's driving behavior. A public information campaign alone will have a minimal effect.

The success of any campaign hinges in large part on coverage given it by local news media. It is, therefore, essential that the hospital medical group or community association work closely with the local newspaper, radio and television stations. Fortunately, most hospitals and medical centers have public information offices with established rapport with local reporters and editors.

Access to the public through the news media can be reached in many ways. Newspapers offer the best opportunity to get a substantive, detailed message across to the public. Through news or feature stories, guest opinion columns, photo essays, and editorials, a newspaper can highlight the message of a drunk driving campaign. But before a reporter or editor will give coverage to an issue, there must be interesting, substantial, and new facts made available to them. What are the local statistics on fatalities, for example? Perhaps there are prominent local citizens who

have been killed or injured in a crash. Permanently disabled crash victims might want to tell their story. Maybe the drunk driver offender will discuss how alcohol affected his ability to drive. How about an interview with patients undergoing rehabilitation therapy? Their words and pictures make a strong impression. In addition, a hospital could release facts about the number of alcohol-related crash victims treated each year, length of stay, and average cost of treatment. If the campaign is strong enough, it would be appropriate to get the media to take an editorial stand on behalf of your efforts.

The Accident Prevention/Chicago program of the Rehabilitation Institute of Chicago skillfully brought media attention to its campaign to raise the drinking age in Illinois from 18 to 21. A videotape was sent to the state legislature showing the difficulties that four young people suffered after a disabling alcohol-related crash. A press conference was held to draw attention to the medical community's support for the bill and to disseminate facts given in testimony by Dr. Henry Betts, Director of the Institute. Follow-up mailgrams to individual senators, the governor, and interest groups throughout the state drove home the safety message. The law was amended.

Radio and television can provide news coverage of a safety campaign but they are also valuable as vehicles for public service announcements (PSAs). Perhaps with the donated help of a local advertising agency, a hospital or a community safety committee could develop a series of PSAs drawing attention to a local traffic problem. Radio and television talk shows are often eager to have knowledgeable guests discuss topics of local interest. It is worth trying to publicize your program in this way.

Reaching out to other organizations • Medical professionals have a unique insight into motor vehicle crashes — the human damage done — which needs to be shared with other professionals.

For example, at the national level, reaching out to different segments of the automobile industry should be a high priority since improved safety design can accomplish much. In addition to auto executives and engineers, there are dealers at the local level who may be particularly receptive to safety efforts. Dealers have constant and close contact with the public and can be excellent sources for distributing brochures and sponsoring programs. In Maryland, automobile dealers formed DADD (Dealers Against Drunk Drivers) and sponsored area-wide countermeasure programs. One DADD group asked dealers to put warning labels on new cars which read: "This device when combined with alcohol can be dangerous to your health." An influential member of the medical profession can be instrumental in starting such programs in his own community. In fact, in some communities, the local hospital is the center point for the drunk driving program.

Begin to work actively with the government. Too often, decision makers in federal, state and local governments do not hear the views and expert testimony of medical professionals. As a result, a vital perspective is often missing in policy deliberations. For physicians to have a real impact with government, they must learn how it works, how agencies regulate auto safety and the specialized language and grammar used by government policymakers.

One way to acquire familiarity with the issues and principles and practice of policy debate is to open lines of communication with the government. Your medical society should maintain contact with the governor's highway safety representative who oversees the state's programs and policies. Periodic advisory committee meetings sponsored by the state offer another opportunity to learn the politics of traffic safety. Why not help start a community task force on the problem? On a national level, the NHTSA has an Office of Alcohol Countermeasures which actively tries to involve citizens from all walks of life in its activities. You and your medical group should ask to be put on the mailing list and to participate in the conferences, panels, and publications sponsored by the Office.

Arguing effectively before state legislatures and municipal bodies requires sophisticated tactics. A combination of good research, media coverage, editorials, letters and phone calls, resolutions by medical societies, and direct personal contact can help persuade legislators to represent your views.

Finally, medical professionals should not neglect the legislative branch. Physicians' views are respected by the representatives. If a representative or senator knew that the medical community back home disapproved of a particular view, he or she could have second thoughts. Ensuring that legislators are accountable to their constituents is difficult for an individual but surely a medical group through its injury prevention committee could keep track of the life-and-death voting decisions made in the legislature. Its possible that national groups with state capital or Washington, D.C. offices could provide assistance. The American Medical Association is vigilant on many other health concerns; why not include drunk driving and automobile safety issues?

Conclusion • Beyond these suggestions, there are other reasons for encouraging active involvement of medical professionals in the drunk driving problem. This issue has seen massive amounts of national attention from citizen activists, voluntary groups and the media. Congress and the President have

acted swiftly responding to political pressure brought about by concerned citizens. States and communities have mobilized by starting programs and forming task forces. However, like many issues that gain national attention, we all must work to sustain the public interest in the drinking and drugged driving problem if we are to obtain long-term success in changing societal attitudes and mores.

If as a society, we are truly interested in dealing effectively with this problem over the long term, then solutions must be institutionalized. It will take a concerted effort by health care professionals, other countermeasure organizations and volunteers to reduce alcohol-related crashes on our highways.

(References available from the author upon request.)

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Prevalence and risk of medication mismanagement by the elderly

Harvey J. Landress, MSW, ACSW and Mary Ann Morck

ABSTRACT: As a result of the high rate of consumption of prescription medications and over-the-counter preparations by the elderly, there is an accompanying potential for patient misuse of such medication. A study of 354 elderly persons in Pinellas County, Florida, was conducted to determine the extent of their medication use and misuse. Additionally, an assessment was made with respect to the extent of their risk of medication misuse. The results of the study indicated that two-thirds of the population surveyed was "at risk" of medication mismanagement as measured by the quantity and frequency of use of prescribed medications. 43% were considered "at risk" with regards to potential misuse of over-the-counter drugs, and 58% were at moderate or high risk of misuse of both over-the-counter and prescription medications. A total of 83% of all respondents engaged in at least one unsafe medicating practice. Taken as a whole, a picture emerges of the elderly being at notable risk with regards to engaging in unsafe medication practices. Suggestions are provided to the physician on how to reduce the risk of medication misuse by their elderly patients.

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Drug therapy, whether physician or self-prescribed, is the cornerstone of treatment for the elderly to improve their quality of life and prevent and treat physical and emotional disabilities. While the elderly as a group nationally consume 25% of all prescription medication,[1] they constitute only about 12% of the population. In some counties in Florida, however, they surpass 40% of the population. The disproportionate consumption of prescription medications and over-the-counter drugs is understandable when one considers that the elderly also suffer from a larger share of serious illnesses.[2] It would appear that the potential for patient misuse of medication accompanies a high rate of drug usage. This paper presents a brief overview of the scope of medication misuse by the elderly, and reports the results of a survey of 356 residents of Pinellas County with respect to medication use practices.

Available research suggests that concern for the elderly because of potential medication misuse is well founded.[3] Research is not always complete and at times quite spotty but a picture emerges as to the areas of misuse which can be clearly identified. Patients and self-prescribers make errors following specific directions of physicians or directions on medicine labels including dose omissions, timing, early discontinuance, use of outdated medications, and exchange of medications. Using prescription drugs with improper combinations of food or other medications or failing to recognize side effects contribute to further complications. One can speculate that failing eyesight, increasing memory defects, not uncommon with the elderly, and confusing medication patterns warranted by multiple medical disorders contribute to medication misusage.

Assessing the scope of the problem • Accurate indicators of patient noncompliance with prescription medications are not available. Hussar[4] noted a wide variation of noncompliance rates ranging from one third to one half of all patients sampled. He reported difficulty in determining demographic variables relating to compliance or noncompliance but did cite characteristics of patients more likely to be in noncompliance such as those with chronic illnesses requiring long-term therapy, who live alone, receive multiple medications requiring frequent administration, and patients with psychiatric illnesses.[5]

Stewart and Cluff[6] also conducted a comprehensive review of patient noncompliance and discovered the rate ranged from 20-80%. They further noted that noncompliance resulted in additional serious health risks in from 4% to 45% of patients.

In a study funded by the state of Florida, Doyle and Hamm[7] surveyed a random sample of elderly residents in Jacksonville. With a response rate of over 70%, nearly 72% reported they did not discuss medications given by one doctor while simultaneously being treated by another and 84% indicated usage of over-the-counter medications — a fact not shared with their physicians or pharmacists. Doyle and Hamm also found that patients tended to discontinue medications they disliked, maintained outdated medications and engaged in the practice of "sharing" prescribed medications. This particular practice was found mostly within family situations. About 40% indicated they did not continue to take medications they disliked and slightly less than half took medications until their physicians told them to stop.

Patient misuse of medication is further prompted by the "If one pill helps a little bit, then two must help me more" kind of logic. This thinking may be encouraged by "take as needed" directions. While relevant research in this area is not abundant, such misuse patterns have been widely noted by those working with the elderly.[8]

Peterson and Thomas[9] examined medical records of the emergency room of a hospital in Dade County and found indications of a high incidence of multiple drug use. Of acute drug reactions, 100% were found to involve legally prescribed medications. Hood[10] has shown that 2% to 8% of all hospital admissions are a direct result of drug-induced diseases and the elderly show a rate 1.5 times that of younger persons.

Because elderly persons have more multiple diseases than the general population, it is not uncommon for them to be seeing more than one physician who may be unaware that their patients are receiving other medications. With such occurrence, the possibility of unfavorable drug reactions increases.

This brief review describing the scope of problems of medication misuse by the elderly served as the basis for a study in Pinellas County in spring 1983 to determine use and abuse patterns among that county's elderly population.

Methodology • Two survey instruments were designed to elicit information regarding prescription drug use, over-the-counter medication, general health and related demographic factors. The first questionnaire included 35 questions and was administered to 271 participants in eight congregate dining and day care sites. The second, an abbreviated version of the first, was administered to 85 individuals at a local "Senior Citizen Showcase of Services" program. Both surveys were part of a special medication management and education program conducted by Operation PAR, Inc. of Pinellas County, a local substance abuse education, prevention and treatment agency.

All questions required a forced choice with an option to explain a notation of "other" and were presented in large bold face type on brightly colored paper to ease any reading problems. Staff was available to assist those with poor eyesight. Several participants indicated inability to read the survey but were in total control of their medication.

Profile of participants • Of 356 people surveyed, 60.1% were women, 92.4% were white, 34.4% were 60 to 69 years old, 39.3% aged 70 to 79, 26.3% 80 and older, 48.1% lived alone while only 2% resided in some form of group care. Several questions were included to determine general health. Respondents were asked to indicate how many of a listing of common ailments they tended to suffer from regularly and 16.6% identified one, 15.5% two, 13.6% three, 28.1% four or more, and 26.2% none (Table 1). In total 73.8% indicated one or more complaints.

Table 1. — Common Ailments Cited By Respondents, N = 271.

Rank	Condition	% Respondents Citing Condition
1	Arthritis	58.5%
2	Colds	49.5%
3	Leg Cramps	48.5%
4	High Blood Pressure	45.5%
5	Gas/Indigestion	30.5%
6	Coughs	25.5%
7	Headaches	24.0%
8	Stomach Problems	19.5%
9	Flu	19.0%
10	Chest Pain	15.5%

Respondents were asked to categorize their health and 85.5% indicated either "fair" or "good," 9.3% "excellent," 5.2% "poor," and 66.8% were under regular care by a physician. When asked how frequently they visited a doctor, 21% indicated once a month, 33% twice a year, and 20.6% once a year. The average respondent was sick 3.4 days in the past two months and 68.4% reported current use of prescribed medication.

The typical survey respondent was female, aged 70-79, lived alone, under regular doctor's care, suffered from three somatic complaints (probably arthritis), considered her health "good," and took prescribed medication.

Prescription drug use patterns • Nine survey questions directly concerned prescription drug use. In addition to eliciting information about the amount and frequency of prescription drug use, the survey questions were designed to identify unsafe medicating practices.

Both the number of different prescribed medications taken and the frequency of such use can be considered possible "risk" factors, especially since drug therapy may involve multiple prescriptions and complicated medication schedules.

Of those persons taking prescribed drugs, 62% were taking one to two, 26% three to four, and 12% five or more. A total of 38% of those who indicated prescription drug use were considered to be "at risk," this being defined as concurrent use of three or more drugs. The more frequently a patient has to be medicated, the higher the risk of error. Recognizing that forgetfulness and confusion are sometimes associated with advancing age, complicated medicating schedules create an additional "risk" factor. Table 2 indicates the number of times survey respondents were medicated daily; nearly two thirds (62.3%) two or more times and more than one third (36.5%) three or more times.

When the data are analyzed, taking into account both the number and frequency of prescribed medications taken, a clearer picture of "risk" emerges. For purposes of this study, "low risk" was considered taking one to two medications once per day, "moderate risk" one to two medications two or more times daily or three or more prescriptions once per day, and "high risk" three or more medications two or more times daily.

Table 2. — Number of Times Patients Medicated Daily, N = 260.

One time	37.7%
Two times	25.8%
Three times	21.9%
Four times	12.3%
Five or more times	2.3%

Table 3. — Patients "At-Risk" of Medication Mismanagement as Measured by Quantity and Frequency of Prescribed Medications, N = 248.

Low risk	32.7%
Moderate risk	36.2%
High risk	31.0%

Table 3 shows the risk factor for patients as measured by quantity and frequency of taking prescribed medications. Of 248 respondents 89% took one to four medications one to four times daily. One third (32.7%) were considered "low risk" while 67.2% were at some level of risk with regards to the quantity of medication taken combined with complicated medicating schedules. The distribution of low-moderate-high risk practices is fairly equal with each representing approximately one third of those surveyed.

One major unsafe medicating practice concerns the failure of patients to adhere to prescribed medicating schedule. Of 286 respondents 41.6% indicated they missed their schedule at least once. When asked why, two thirds (67.1%) said they forgot and one third (32.9%) purposely did not take the drug. These reasons are detailed in Table 4.

When asked what they would do in an incident of missed medication, 74.8% indicated they would wait until the next appropriate time and 13.2% stated they would take another dose as soon as they realized the previous dose was missed.

Of 287 respondents 21.3% said they had quit taking medicine when feeling better. When asked what they did with left-over medication, one third (34%) said they saved it for later, 2.3% shared it with someone else and two thirds (63.7%) threw it out. Maintaining unused medications and sharing with friends are two unsafe behaviors practiced by 36.3% of all respondents.

Table 4. — Reasons Cited for Missing Medications, N = 176.

Forgot	67.1%
Felt better	15.3%
Did not help	6.8%
Felt worse	4.5%
"Others"	6.3%

When asked how many old prescriptions they had on hand, 11.2% indicated they had none, 69.4% from one to three, 13.8% from four to six, and 5.8% seven or more. In total 88.8% had one or more unused prescription medications at home and 19.4% four or more. Such persons are considered to be at higher risk of medication misuse.

When assessing patients' knowledge or understanding of potential side effects, 65.9% indicated they were aware of these potentials while one third (34.1%) indicated no knowledge or understanding. This represents another risk factor for the elderly.

Survey respondents were also asked to identify what they would do if they felt "sick" and did not go to the doctor. The results are noted in Table 5. Only 20.1% indicated they would secure advice from either a physician or pharmacist. These are the only responses that involve a medical professional. Of the respondents 79.9% engage to some degree in self-diagnostic and self-prescribing behaviors. When asked if they ever telephoned the doctor for a prescription, 42.9% of 322 respondents answered affirmatively.

Table 5. — Patient Response to Illness Without Seeing Physician, N = 204.

Do nothing	33.3%
Buy something from the store	19.1%
Use home remedy	15.2%
Use old prescription	11.8%
Talk to pharmacist	9.3%
Talk to doctor	10.8%
Borrowed from friends	0.5%

It is interesting that only 0.5% used medications borrowed from friends; however, it was previously noted that 2.3% shared medications. This indicates that patients may share with others but very few use such borrowed medications.

Thus, it can be seen that the elderly are at risk with respect to the amount and frequency of medication utilized. Additionally, a substantial portion engage in one or more unsafe practices including failure to adhere to medicating regimen, keeping unused medications, not knowing or understanding potential side effects and engaging in self-diagnostic/self-prescribing behaviors. The latter is, without doubt, encouraged by the massive advertising of over-the-counter preparations. People are encouraged to review their symptoms, assuming the condition does not warrant a physician's visit, and become their own diagnostician and pharmacist.

Over-the-counter medications • Of survey respondents 49.1% indicated use of over-the-counter (OTC) drug preparations and 44.5% of 317 respondents indicated they used OTC medications while concurrently using prescription medication.

Because OTC drugs may have serious side effects if used inappropriately for prolonged periods of time or in conjunction with prescribed medications, respondents were asked if they consulted with their physician when taking OTC and prescription drugs. Table 6 shows that nearly three fourths either never (41.3%) or sometimes (29.7%) consulted their physician.

Respondents were surveyed to determine how they received information about OTC drugs. Responses are noted in Table 7. More than one third (35.4%) relied on their doctor and one fifth (20.5%) on their pharmacist. Thus, more than half of those surveyed (55.9%) depended upon professional advice. The number of respondents who relied on advertising (18.3%) as well as advice from friends and relatives (17.8%) was almost equal. Only 9% gained information from product labels.

When asked if they were able to read over-the-counter product labels or instructions, 73.8% responded "always," 18.1% "sometimes," and 8.1% "never." Thus, more than one fourth (26.2%) of 309 respondents indicated difficulty reading product labels. This inability is a notable risk factor.

Respondents were surveyed regarding their personal use of OTC drugs. They were asked to indicate how many of what kinds of medications they had on

Table 6. — Consulting a Physician When Using Over-the-Counter and Prescribed Medications, N = 259.

Always consulted	29.0%
Sometimes consulted	29.7%
Never consulted	41.3%

Table 7. — Over-the-Counter Medication Information Sources, N = 268.

Doctors	35.4%
Pharmacists	20.5%
Advertising	18.3%
Friends/relatives	17.8%
Product labels	9.0%

hand. Ten common OTC drug types were listed along with the ability to note "others." Table 8 indicates the most frequently cited OTC medications. The most popular was aspirin/pain reliever (25.9%), second laxatives/diuretics (16.3%) followed closely by vitamins (15.6%). These three accounted for nearly 60% of the most frequently kept OTC medications. When antacids (9.5%), cough remedies (8.8%) and cold medicines (7.3%) are also included, they cumulatively account for 83.4% of the most frequently used OTC preparations.

When it is considered that occasional or prolonged use of these drugs can lead to adverse reactions not only when used by themselves but especially in conjunction with prescribed medications, there is notable increased risk for the elderly taking such drugs. This is especially so when OTC drugs cause symptoms simulating other disorders. A danger arises when these symptoms are treated by the patient or physician and not recognized as being drug related.

Respondents were asked the number of OTC medicines they had on hand at home (Table 9). Only 18.9% indicated none, 39.5% one to three, and 41.6% four or more. Additionally, of the 41.6% of the elderly who had four or more drugs on hand, 19.4% indicated they also had four or more different prescription medications. The risk of experiencing problems with OTC drugs taken in combination with prescription drugs increases as the frequency of each variable increases.

It is interesting to note that while 18.9% said they had no OTC drugs on hand at home, 51.9% said they did not use OTC drugs. This difference can be explained in only two ways: either the drugs were on hand and never used or, more likely, they used OTC drugs but did not consider them "over-the-counter" medications.

Risk levels were established based on the assumption that the risk of incompatible combinations of prescribed and OTC drugs increases in relation to the quantity available. The following risk levels were established:

Risk Level	Definition
No risk	No OTC drugs and no prescriptions
Low risk	0-3 OTC drugs and 1-2 prescriptions 1-3 OTC drugs and no prescriptions
Moderate risk	0-6 OTC drugs and 3-6 prescriptions 4-6 OTC drugs and 0-2 prescriptions
High risk	7 or more OTC drugs or 7 or more prescriptions

Analysis of the data is indicated in Table 10. Only 4.2% of respondents had no risk and 37.6% low risk; therefore, 41.8% had low or no risk with respect to OTC and prescription drug use. However, 58.2% indicated risk levels from moderate (44.6%) to high (13.6%). Thus, it can be concluded that a notable majority of the elderly are at risk of medication mismanagement because of the number of prescribed medications they take as well as the number of over-the-counter preparations they maintain on hand.

Several factors explored in the survey can be identified as unsafe medicating practices: discontinuance of medication if feeling better, saving old/leftover medication for future use, when sick, engaging in self-diagnostic/medicating practices such as buying something from the drug store, using an old prescription, using a home remedy, or borrowing medicine from a friend or relative, using over-the-counter and prescribed medications concurrently with no consultation with a physician, and missing taking prescription medication.

Table 9. — Quantity of Over-the-Counter Drugs on Hand, N = 354.

None	18.9%
1	11.6%
2-3	27.9%
4-7	36.2%
8-12	5.4%

Table 8. — Most Frequently Kept at Home Over-the-Counter Medications, N = 354.

Aspirin/bufferin	25.9%
Laxatives/diuretics	16.3%
Vitamins	15.6%
Antacids	9.6%
Cough medicines	8.8%
Cold medicines	7.3%
Nasal Spray	4.3%
Iron pills	3.5%
Sleeping pills	3.2%
Mineral oil	1.9%
Others	3.7%

Table 10. — Risk Levels of OTC and Prescription Drug Use, N = 354.

No risk	4.2%
Low risk	37.6%
Moderate risk	44.6%
High risk	13.6%

Information was available on the prevalence of each unsafe medicating practice. Table 11 shows their distribution. The most frequently cited was concurrently using prescription medications and OTC drugs without medical consultation (70%). Self-diagnosis/self-medication (57.5%) ranked second while telephoning for a prescription (42.9%) ranked third. It should be noted, however, that risk increases as more than one unsafe medicating behavior is practiced.

A total of 83.1% of all respondents indicated at least one unsafe medicating practice. Table 12 shows the rate and risk of involvement. Of those surveyed 43.7% were considered low or no risk. On the other hand 56.3% were moderately at risk (49.3%) or at high risk (7%).

Risk is further increased when it is considered that 26.2% had difficulty reading labels. Further, 23.4% took medications which were similar in color or shape and 23.9% "sometimes" and 9.6% "always" had difficulty distinguishing one medicine from another.

Taken as a whole, a picture emerges of the elderly being at notable risk with regard to engaging in unsafe medication practices. For the physician, the level of risk for elderly patients could be reduced or ameliorated by the following actions:

Specifically asking patients whether they are taking other prescribed medications or OTC preparations.

Specifically instructing patients on the use of the medications.

Asking patients to contact the physician if new symptoms develop while they are taking prescribed medication.

Discussing potential side effects of medications so patients will not self-medicate such symptoms.

Inquiring whether there is difficulty taking medications such as confusion in color, size or shape.

Discussing their OTC drug self-medicating behaviors.

While no single action can decrease medication mismanagement by the elderly, the physician does have an important role to play in creating a climate whereby potential, unsafe medicating practices can be identified and discussed. The results of this study as well as other research clearly demonstrates that a majority of the elderly engage in unsafe medicating practices. By asking a few additional questions and clearly discussing proper use of prescribed and over-the-counter medications, risk of mismanagement can be reduced.

Table 11. — Respondents Engaging in Unsafe Medicating Practices, N = 354.

Using OTC and prescription drugs without medical consultation	70.0%
Self-diagnosis/self-medication	57.5%
Phoned doctors for prescription	42.9%
Missed prescription	41.6%
Failed to discard old medicines	36.3%
Discontinued prescription if feeling better	21.3%

Table 12. — Rate and Risk of Involvement in Unsafe Medication Practices, N = 354.

No unsafe practices	16.9% (no risk)
1 unsafe practice	26.8% (low risk)
2-4 unsafe practices	49.3% (moderate risk)
5-6 unsafe practices	7.0% (high risk)

References

1. Pascarelli, E.: Drug Dependence: An Age-Old Problem Compounded by Old Age, Geriatrics 29:209-225, 1974.
2. Manard, B.B.: Old Age Institutions. Lexington, Mass., Lexington Books, 1975.
3. Butler, R.N.: Introductory Statement, Proceedings, Medication Mismanagement and Education of Elderly, Nutley, N.J., Excerpta Medica, 1978.
4. Hussar, D.A.: Patient Noncompliance, J.A. Pharmacological As. 15:183-190, 1975.
5. Prentice, R.: Patterns of Psychoactive Drug Use Among the Elderly, in The Aging Process and Psychoactive Drug Use, Washington, D.C., National Institute of Drug Abuse, 1979.
6. Stewart, R.B. and Cluff, L.E.: Review of Medicating Error and Compliance in Ambulatory Patients, Clin. Pharmacol. Therap. 13:463-468, 1972.
7. Doyle, J.P. and Hamm, B.M.: Medication Use and Misuse Study Among Older Persons. Jacksonville, Fl., The Cathedral Foundation of Jacksonville, Inc., 1976.
8. Peterson, D.M. and Whittington, F.J.: Drug Use Among the Elderly: A Review, J. Psychedelic Drugs, 9:25-37, 1977.
9. Peterson, D.M. and Thomas, C.W.: Acute Drug Reactions Among the Elderly, J. Gerontol. 30:552-556, 1975.
10. Hood, J.C.: Improving Use of Medication by Elderly Patients — A Learner's Manual for Pharmacists and Pharmacy Students, St. Petersburg, Operation PAR, Inc., 1979.
11. Doyle, J.P. and Hamm, B.M.: Op. Cit.

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Treatment of late-life onset alcohol abuse

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ABSTRACT: This paper describes the Gerontology Alcohol Project (GAP), a pilot research and treatment program designed to address the problem of "late-life onset" alcohol abuse, defined as onset of alcohol abuse after age 50. The treatment approach developed has been found highly successful based on a one year follow-up. GAP's success with late-life onset alcohol abusers has resulted in the inclusion of "early-onset" elderly alcohol abusers within its treatment population.

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In recent years researchers and health services professionals have observed that excessive alcohol consumption is one method the elderly use in response to the stresses associated with aging. Two major classifications of elderly problem drinkers have been identified.[1-4] The "aging alcoholic" who has abused alcohol throughout life is well known to community service and legal agencies and often receives diverse social services. This individual developed a drinking problem as a younger person and it survived through old age. The second category, the "geriatric problem drinker," can be divided into two types: the individual who has experienced occasional alcohol-related difficulties but who began abusing alcohol during late middle or old age, or the "late-life onset" alcohol abuser, the individual who began abusing alcohol late in life in response to the stresses of aging. The number of late-life alcohol abusers is believed to constitute about one third of the estimated 7 million elderly alcohol abusers residing in the community.[3] Zimberg [1-3] suggests that late-life abusers drink in response to external factors associated with aging and that the emphasis of treatment be upon the psychosocial stresses of aging and rebuilding the social network.

The Department of Aging and Mental Health of the Florida Mental Health Institute located at the University of South Florida, Tampa, was awarded a three year grant from NIAAA to conduct research specific to the location, description, and treatment of late-life onset alcohol abusers. The research was implemented through the pilot day treatment program known as the Gerontology Alcohol Project (GAP).[5,6] Late-life onset alcohol abusers were defined as individuals age 55 or older who began abusing alcohol after age 50. The project had the task of

answering three questions: Do late-life onset alcohol abusers exist as a clinical entity? What strategies or approaches should be employed to identify and enter them into treatment? What treatment modalities are appropriate for use with this particular population (and can be replicated in other treatment settings)? The description and results of GAP have been reported previously.[5,6] The following, however, represents a brief summary of these findings.

Method • During the 24-month "treatment phase" of GAP, 406 referrals were made mostly through social service agencies. The final six months of the treatment phase were considered a "phasing out" period as the grant ended and the frequency of referrals decreased markedly as new admissions entered into our Community Aging Program rather than GAP.

Three fourths of the 406 referrals were in fact over age 55 and one half of these met the GAP criteria for late-life onset alcohol abuse. However, this number could have been considerably higher. For 30% of the cases, the referral sources could not provide a verifiable age of onset of the drinking problem and unless it was known that the drinking problem did not occur until after age 50 the referral was ruled as "early onset" and inappropriate for the pilot research and treatment program.

The mean age of appropriate referrals was about 66 and the mean age of onset alcohol related problems was 60. About 61% were males. Only 70 people consented to a screening visit after which 48 (26 males and 22 females) agreed to participate in the initial program.

Assessment • A variety of assessments were used to describe the research group, assess progress in treatment as well as evaluate the effectiveness of the program.[6] These instruments included a modified Drinking Profile[7] and the collateral's ratings of the client.[8] The collateral was chosen based on his or her knowledge of the client's "real world" behavior. The assessments allowed us to evaluate an individual's quality of life via indicators such as physical and mental health, family and social adjustment, financial stability, and legal status.

Treatment • GAP used a behavioral and self-management treatment approach. The information derived from responses on the Drinking Profile was used to identify components of the client's unique drinking behavior chain. The clients were next entered into treatment modules (or groups) specific to the antecedents for alcohol abuse noted in their individual drinking behavior chains. In these modules, they were trained in skills necessary to terminate or interrupt their drinking behavior chains and assessed regularly to determine progress and acquisition of skills. Standardized procedural manuals for staff leading these groups have been developed as well as behavioral rating scales. In the first module, the Analysis of Drinking Behavior (or ABC's of Drinking), clients learned how to analyze their personal behavior chain into antecedents (situation, thoughts, feelings, cues, and urges or self statements which precede taking a drink), behavior (drinking), and consequences (positive and negative, as well as short vs long term).

Following completion of the ABC module, clients entered the Self-Management module. Self-Management consisted of seven segments designed to counteract such common antecedents to abusive drinking as peer pressure (drink refusal), cues, urges, relapse (experiencing a "slip"), tension/anxiety, anger/frustration, and depression. These components varied in the number of sessions according to content. In the General Problem Solving Skills module, elderly clients were instructed in methods of problem identification, generating solutions, and decision making. The fourth module, Alcohol Information and Education, was primarily a lecture oriented group designed to educate the older client to the effects of alcohol abuse, aims of the treatment program, and current research findings.

Depending upon behavioral deficits determined by other assessments, clients might also enter training for other social skills which were part of the larger ongoing Aging Programs.[9] Other behaviors not addressed by the treatment modules could be handled via individualized treatment. In any case, the treatment plan was decided upon by a "treatment team" comprised of a psychologist, nurse, case manager, social worker, and unit manager.

Results • Prior to admission GAP clients were, for the most part, living alone often due to death of a spouse or divorce, in reasonably good health, financially stable (but not affluent), and experiencing few mental health problems. The most notable characteristic were that these individuals had very small social networks (a total of about seven people was the average number of friends and relatives with whom they had contact at anytime) and reported negative mood states prior to drinking (primarily depression, loneliness, grief).

Most clients drank daily consuming an average of 12.2 SECs (Standard Ethanol Content units) on a typical drinking day, the equivalent of about ten cans of beer, or 51 ounces of wine, or over 15 ounces of 80 proof liquor per day.

Of the initial 48 clients admitted to the pilot program, 24 dropped out and 24 "graduated" and participated in a one year follow-up/aftercare program. During follow-up, assessments were administered at one, three, six and 12 months post-discharge.

The results indicated that the clients maintained high "marks" on quality of life indicators and improved the size of their social networks. The collateral's ratings also verified that these skills were being maintained throughout follow-up. Furthermore, a specific subscale of the collateral's ratings on alcohol and drug abuse indicated maintenance of the individualized drinking goals.

Of the 24 "graduates," 17 chose a goal of abstinence, and all but three were able to maintain this throughout follow-up. Seven chose a goal of limited drinking, of which three maintained this goal, one did not maintain, one died of causes unrelated to alcohol, and two dropped out of follow-up. Overall success varied from 100% of the graduates at day of discharge to 74% at the 12 month follow-up. Success meant that the person had maintained his individual drinking goal for the follow-up period. Thus, GAP's definition of success was extremely conservative. For example, those who dropped out of follow-up were considered failures (from a statistical standpoint) and those who exceeded their drinking goal only once during any of the four follow-up periods were still considered to have violated their drinking goal for all of the specified follow-up period. Our statistical conservatism, while still noting the excellent drinking goal success rates, also masked otherwise excellent goal-related performances (i.e., all of the clients who violated their drinking goals returned to their goals almost immediately, and none returned to an abusive drinking pattern throughout the entire 12 months of follow-up).

Present status of GAP and conclusions • The Gerontology Alcohol Project, considered a pilot program, did in fact find that there are substantial numbers of late-life onset alcohol abusers living within the community. The philosophy of teaching self-management skills specific to the bases (antecedents) for abusive drinking appears to have been effective. Furthermore, other aspects of the Aging Program enabled these individuals to learn skills to increase their social networks, compensating for other major interpersonal losses.

References

1. Zimberg, S.: Elderly Alcoholic, Gerontologist 14:221-224, 1974.
2. Zimberg, S.: Treatment of Elderly Alcoholic in Community and in Institutional Setting, Adictive Diseases 3:417-427, 1978.
3. Zimberg, S.; Wallace, J., and Blume, S.: Practical Approaches to Alcoholism Psychotherapy, N.Y., Plenum Press, 1968.
4. Carruth, B.; Williams, E.P.; Mysak, P., and Boudreaux Jr., L.: Community Care Providers and Older Problem Drinker, Proceedings of the 24th Annual Meeting of Alcohol and Drug Problems Association of North American, 79-83, 1973.
5. Dupree, L.W.; Schonfeld, L.; O'Sullivan, M.J., and Cohen, M.: Bringing Medication and Alcohol Abuse Under Control: Self-management Techniques for Elderly. In Marlowe, H.A., and Weinberg, R.B., (eds.) Competence, Coping and Emotionally Handicapped, Tampa, University of South Florida Press, 301-339, 1983.
6. Dupree, L.W.; Broskowski, H., and Schonfeld, L.: Gerontology Alcohol Project: Behavioral Treatment Program for Elderly Alcohol Abusers, Gerontologist, in press.
7. Marlatt, G.A.: Drinking Profile: Questionnaire for Behavioral Assessment of Alcoholism, In Mash, E.J., and Terdal, L.G. (eds.) Behavior Therapy Assessment: Diagnosis, Design, and Evaluation, N.Y., Brenner/Mazell Publishers, 1976.
8. Ellsworth, R.B.: Personal Adjustment and Role Skills (PARS) Scales, Roanoke, Virginia, Institute for Program Evaluation, 1979.
9. Patterson, R.; Dupree, L.W.; Eberly, D.A.; Jackson, G.M.; O'Sullivan, M.J.; Penner, L., and Kelly, C.D.: Overcoming Deficits of Aging: Behavioral Approach, N.Y., Plenum Publishing, 1982.

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Observations on drug dependency

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ABSTRACT: Clinical observations drawn from the treatment experience of 3700 opiate dependents. Emphasis is placed on the social and cultural stresses acting upon a susceptible individual who is adapting to the demands of an increasingly complex society. The specific drug is relegated to the role of an agent satisfying a need, rather than the cause of the dependency state.

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Since 1970, I have been involved in the management of some 3,700 patients attending an opiate addiction facility. The appalling destruction of young people during this period has engendered many hours of discussion with colleagues and self-reflections. Repeated interviews with patients, their families and co-workers have revealed that most of us have a woefully inadequate understanding of the drug dependency problem. A distinct change has occurred since I rode an ambulance in 1940 and 1941 in New York City. The most notable differences are seen in the opiate addict, i.e., the youth of addicted patients, the great variety of drugs employed, general acceptance by peers and pressure to use drugs especially in children and adolescents, ready availability and widespread distribution of drugs, and the indifference of the general population to the reality of the problem.

Given this scenario, we are asked to raise our children to be responsible to themselves and to society. It is my intention to present my clinical observations as to some of the factors behind the current widespread prevalence of drug dependency.

History has recorded the use of mind-altering drugs by man for centuries. Opiates, cocaine, alcohol, cannabis and tobacco have all been the subjects of historical comment. These drugs have been marketed for both economic and political advantage with the goal of controlling markets and masses of people. Opiates have also been used medicinally and recreationally and a free market existed in Great Britain and the United States as recently as 100 years ago. Opiates are effective psychotherapeutic agents and have also been used as self-medication by psychiatrically disturbed individuals. This had been true prior to development of the current psychoactive

array of drugs. The introduction of the hypodermic syringe with purified morphinoid products changed the picture. Upon introduction of restrictive legislation, the practice of drug abuse was driven underground and subsequently marked with the development of a cultural mystique.[1,2] A pattern of illicit drug abuse followed with progressive entanglement of susceptible individuals.

Advertising techniques have pushed public expectations beyond reality. "A pill for every ill" might be considered a reasonable slogan for some strata of society. The media have depicted violence, sexual license and countercultural ritualistic behavior with the goal of generating income. The media have assumed the role of disseminating medical information and spectacular technical achievements have been proclaimed prematurely with little consideration of the subtle long-term effects. These have been left for future generations to face. Serious problems confronting society are openly presented, often threatening in nature with no readily available solution. Crime has become a way of life and is highlighted by the press and television.

Factors in drug dependency • The interplay of multiple factors should be considered when trying to understand drug dependency. Whether one looks at the problem from a behavioral or a psychodynamic point of view, there appears to be a constant interplay of personal and environmental factors. This is found to be most prominent in the opiate addict with whom I have had the greatest amount of experience. Some factors are of contributory nature and are poorly appreciated or probably unknown at the present time; however, the following is a listing of those I have found to be of importance:

Deficiency of ego strength • Poor self-image has been repeatedly found in opiate addicts. The cause is obscure but there has been a frequent undercurrent of family dysfunction. Upon review of our records we estimate that severe dysfunction is present in approximately 50%-60% of our addicted patients. Poor support systems were often present during the formative years of the patient and at times with obvious gross neglect of the child. The patient was often called upon to make his own decisions at a time when he was poorly prepared to do so. Parents functioned as inadequate role models to the growing child and adolescent. Alcoholism, especially in the father, and divorce have been most striking findings. Emotional lability, family turmoil and violence were not uncommon, as well as instances of incest of fathers with daughters. Not unfrequently, the adolescent has been introduced to the use of opiates by a sibling. Subsequent failures in school and interpersonal relationships follow, and contribute to a vicious cycle of personal inadequacy, guilt and shame.

Cultural attitudes • A subculture of society has developed that accepts drug usage as "normal" behavior. I like to call this acceptance of the unacceptable "a countercultural drift." Elements of defiance and dissatisfaction are prominent. The behaviors of members of this countercultural group are rooted in personal inadequacy and frustration with frequent acting out of emotional tensions. Subcultural role models are distorted, fantasy satisfying and countercultural in texture. Distortion of externalized superego figures would suggest loss of external locus of control. The patient becomes more comfortable with his peers in a new licentious environment. Reinforced with an array of protective and mind-altering drugs, sexual license and relief of frustration by physical aggression and rage cause progressive involvement in activities of the group. "Normal" maturation in society is neglected for the sake of the protection of the group. An "addiction set"[3] has been described with such stereotypical behavior.

Socioeconomic frustration • A significant segment of our population is poorly prepared to move in the mainstream of our complex society. Many people are socially and economically deprived, in most instances with little chance of escape. Discrimination for basically economic reasons is well known. This may be artifically based on race, religion, ethnic origins, sex, etc. and contribute to the total frustration and sense of hopelessness of the victims of such discrimination. Resentment may follow the imposition of a ghetto atmosphere. Antisocial behavior, widespread drug abuse and profiteering through sales of drugs commonly follow. Power, money and status are often followed by disastrous drug dependency by the very person selling the drugs.

Conditioning • The importance of conditioning contributing to repeated drug abuse has probably been underestimated. Drugs of abuse are used for their pleasurable effects. Insulation from environmental and personal stress is frequently sought by the patient. Drug abuse may become a disease of its own origins (sui generis). When this point is reached, all efforts at motivation and deconditioning become exceedingly difficult. We may then consider that drug abuse becomes a learned behavior.

Psychiatric dysfunction • We regard a great deal of the drug abuse seen at our facility as adaptive in origin. Opiates may be viewed as coping devices for feelings of personal incompetence. In some patients, they are likely a form of self-medication that permits some degree of function in a very complex society. The protective effect of opiates has been described by patients as "mother heroin," perhaps best expressing a desire to return to the protective environment of the uterus as a sheltered child being.

Fluctuations in mood are common. There are periods of apparent placidity alternating with periods of violence and self-destruction. We have described this behavior as a "repeated flirtation with death." The weak ego seems to be meeting the challenge of a punishing externalized superego with the ever-present threat of a needle. We have reported one such patient who exhibited intense rage and attempts at self-mutilation who used opiates to control her feelings.[4] Prolonged psychiatric care prior to use of opioids failed to control her behavior. She had been seen by numerous psychiatrists, made multiple suicidal gestures and had been treated with electroconvulsive therapy. When first seen, she was in a psychiatric institution and the attending psychiatrist noted that when she was on self-administered heroin her behavior was placid and well controlled. She was treated for heroin addiction, responded satisfactorily, and after two years was detoxified successfully. When last seen, she was well, had recently married, and had been drug free for at least four years.

Dysfunction ranging from borderline personality disorder to frank depression is known to be common. It has been variously estimated that 50% of opiate addicts have significant depression. We have seen patients diagnosed as schizophrenic by competent psychiatrists. These patients usually present with a pattern of polydrug abuse and are quite difficult to control. It is also of interest that most opiate addicts smoke, many ingest significant amounts of alcohol and many are insomniacs. Tattooing is very common and is believed to represent symbolic references frequently to unresolved problems. Compulsive gambling has been a problem in some patients who have gone "clean" from the program. It is my belief that homosexuality, especially uncompensated, is a significant problem. There is a frequent reference to the maternal figure and a sense of frustration, guilt and frequently unrequieted reproductive drives that seem to be plaguing these patients.

Loss of superego figures • The restraining influence of social ideals has been eroded. This is evidenced by the continuous waning of the influence of the family, loss of family integrity, progressive weakening of religious control, and loss of idols, particularly among young people in the area of politics, sports and other phases of life. Respected figures in society, e.g. physicians, police, teachers, sports idols, and politicians, have been found fallible and have been replaced by mechanistic, unforgiving and punishing realities. The need to construct a protective shell may be envisioned as an effort to function in a very complex society.

Genetic and congenital • The physically disadvantaged patients pose a special problem that will not be addressed at this time. The influence of genetics on chemical dependency has been argued about for years. Whether an individual inherits a predisposition for drug abuse is unknown. The recent description of opiate-like neurotransmitters associated with specific receptor sites in the nervous system raises the question of inherited defects in this system. Whether defects in the receptor sites or endorphin/enkephlin system neurotransmitters exist in opiate dependence is unknown.[5,6] The role of this system in the capacity to respond to stress and pain is currently being explored. Similar mechanisms may be postulated for other classes of chemical dependency but are unproven.

Physiologic dependence • Beyond the ritual of the use of a needle is a physiological dependency that develops from the prolonged use of certain psychoactive chemicals. The nervous system is exposed to agents altering its function, possibly involving receptor sites, neurohumoral agents, cell membrane stability and other mechanisms. Suppression of normal functions can be postulated during the period of chemical dependency. Recovery time is required upon withdrawal of some agents for stabilization of functional balance of the nervous system. This period may be associated with seizures (barbiturates, benzodiaxepines), autonomic instability (opiates) and emotional lability (cocaine).

It is interesting to note that some opiate addicts self-detoxify themselves for extended periods with suprisingly little difficulty only to return to drug abuse under periods of stress. The detoxification is often achieved most successfully by change in locale and social structure. In 40 years of internal medical practice I do not recall ever seeing the medical induction of opiate addiction in patients with correctable medical conditions. A similar experience has been reported in patients whose drug abuse was induced under unusual stress (e.g. Vietnam).

I have, therefore, concluded that the major problem lies in the patient's need. The drug is regarded by the patient as a very effective and rewarding agent and is probably not the primary cause of the dependency state.

Comments and conclusions • Clinical drug dependency is presented largely as another means by which man inadequately adapts to his environment. Initially it is sought for pleasure and probably has some survival value. A secondary destructive state may develop that overwhelms the original cause of the addiction. It may become a disease of its own origin (sui generis). This is especially true with opiates which represent a very effective group of psychoactive agents.

Years ago, drug experience was primarily with oral ingestion and inhalation of relatively crude products. It was believed by many that this may have represented a form of self-medication with the use of the then available psychoactive drugs in the form of opiates. The element of danger became accentuated with the advent of the hypodermic injection of purified opiates (frequently adulterated). The chewing of cocoa leaves in South America can hardly be equated with nasal instillation, freebasing and the intravenous use of cocaine. Cannabis products have been used in crude forms and are smoked essentially unchanged from previous experience. The paradox of legalization of alcohol and tobacco can only be ascribed to economics. These represent the most dangerous group of drugs and are implicated in the greatest number of deaths induced by chemicals by far. Yet our government insists in permitting a free market in the use of these drugs which are well documented to be lethal.

Drugs in and of themselves have frequently been blamed for the current problem of widespead abuse. They have been catagorized as "good drugs" and "bad drugs." It is commonly believed that elimination of "bad drugs" would solve the problem. It must be remembered that all drugs have specific physiologic effects, in this instance primarily on the nervous system. They may be classified as neither good nor bad. I submit that the problem lies with the individual using the drugs and not with the drugs themselves. The dependency may be felt more strongly related to the effect induced by the drug, not of the drug itself. This is an important point of differentiation. Selection of an agent is probably based on need and availability and is primarily related to the effect produced by the drug. A state of physiological dependence may exist but should be controllable if an adequate period of time is permitted for restabilization of the function of the nervous system. It has been felt that suppression of normal neurotransmitters or exhaustion of neurotransmitters may lie at the root of the so-called abstinence syndromes and that an adequate period of time would allow the organism to restore its normal neurohumoral homeostasis provided that the underlying problem can be resolved. It is informative to see the opiate addict fluctuate in his patterns of abuse often based on finances, social behavior and availability. It is difficult to explain the mixed drug abuse, e.g. opiates, cocaine, cannabis, alcohol, tobacco, assorted sedatives, etc., on a physiological basis when each class is believed to act by a different mechanism. An approach stressing the patient's need of "what the patient is telling you," should probably give greater insight into the roots of the disorder.

In summary, development of the patterns of drug abuse has been presented in a simplistic fashion. It is far more complicated when investigated in depth psychodynamically.[7] The emphasis on the person rather than the drug has been done deliberately in an effort to place emphasis in its proper perspective. The danger is there and man may be faced with hard choices before the problem is solved. Man may be viewed as highly intelligent but, perhaps, not very wise. Can man cope emotionally with his intellectual achievements without resorting to chemicals? I hope he ultimately can.

References

1. Berridge, V.: Opiate Use in England, 1800-1926, Ann. N.Y. Acad. Sci. 283:1-11, 1982.
2. Way, E.L.: History of Opiate Use in Orient and United States, Ibid 238:12-23, 1982.
3. Brill, L. and Lieberman, L.: Authority and Addiction, pp 204-206, 1969, Little, Brown & Co.
4. Berken, G.H.; Stone, M.M., and Stone, S.K.: Methadone in Schizophrenic Rage, A Case Study, Am. J. Psych. 135 (2):248-249, 1978.
5. Khantzian, E.J.: Psychological (Structural) Variability and Specific Appeal of Narcotics, Ann. N.Y. Acad. Sci. 238:24-30, 1982.
6. Simon, E.J.: Opiate Receptors and Opiate Peptides: An Overview, Ibid 238:327-338, 1982.
7. Wurmser, L.: Question of Specific Psychopathology in Compulsive Drug Use, Ibid 238:33-43, 1982.

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FLORIDA MEDICAL

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NOTES & NEWS

Henry M. Yonge, M.D. elected to Southern Medical Association post

Henry M. Yonge, M.D., native Pensacolian and former president of the Escambia County Medical Society, was elected secretary of the Internal Medicine Section of the Southern Medical Association at its November 1983 meeting in Baltimore.

Dr. Yonge, who has practiced internal medicine in Pensacola since 1952, currently is Chairman of the Florida Medical Association Council on Scientific Activities and is a candidate for Secretary of the Association.

He is a graduate of Washington and Lee University and Tulane Medical School. After serving as a captain in the Army Medical Corps in World War II, he attended graduate school at the University of Pennsylvania and was an instructor in internal medicine at the University of Michigan. He has also served three terms on the Medical Advisory Committee to the Dean of the University of Florida College of Medicine.

Dr. Yonge and his wife, Pat, have two sons and one granddaughter.

Florida area surgeons obtain special certification in vascular surgery

The American Board of Surgery, with the approval of the American Board of Medical Specialties has offered Certification of Special Qualifications in General Vascular Surgery. By definition, this Special Certification is offered to those whose training and activities encompass General and Thoracic Surgery. It is intended to be limited to those surgeons who by virtue of additional approved training beyond that usually acquired in a residency in Surgery and/or Thoracic Surgery have demonstrated exceptional knowledge and skill. Those Florida surgeons qualifying based on the first examination offered in November 1983 are Raymond H. Alexander, M.D., Jacksonville; Mario H. Avila, M.D., Lauderdale Lakes; Theodore D. Aylward, M.D., New Port Richey; William M. Blackshear Jr., M.D., Tampa; Floyd T. Bryan, M.D., Melbourne; Harold R. Gertner, M.D., Gainesville; William D. Long, M.D., Tallahassee; Barry J. Mankowitz, M.D., Marathon; Franklin G. Norris, M.D., Orlando; Daniel B. Nunn, M.D., Jacksonville; and Stephen Schreiber, M.D., Altamonte Spring.

UF College of Medicine alumni throughout the world invited to share in silver anniversary events

An opportunity to attend dedication of Shands Hospital's new Patient Services Building and to reminisce with former classmates and faculty, awaits alumni of the University of Florida's College of Medicine, when they meet on campus for a silver anniversary celebration May 18-20.

The college is celebrating the graduation of 25 classes (1960 - 1984), from which 1,871 persons received their M.D. degrees and more than 1,900 physicians have completed residency training in various medical specialties.

Former college administrators and faculty members are invited to join alumni, from throughout the nation and many foreign countries, as participants in the three-day commemorative program.

Through a fortunate timing of events, medical alumni returning to Gainesville for the anniversary events will be among the first to tour the recently completed $62.5 million facility — including a modern 8-story wing that now houses almost all patient care activities. Leaders of state and local government also have been invited to attend the historic occasion, on the front lawn of Shands near the new hosptial entrance off Archer Road.

Among the latest innovations in clinical services which alumni will see on tour are the specially designed intensive care facilities, spacious new emergency rooms and operating rooms, and the nuclear magnetic resonance (NMR) scanner which is the first of its type to be activated for medical diagnostic usage in Florida.

Highlights of the anniversary weekend also will include a reception Friday, May 18, from 7:30 to 10:30 p.m. at the Florida State Museum, and a scientific colloquium opening at 9:30 a.m. Saturday in the Chandler Stetson Memorial Sciences Auditorium at UF's Health Center. Three outstanding medical alumni will present lectures, and special awards will be presented to two medical scientists for outstanding achievements in basic science research and in clinical research.

Honored guest for the colloquium and other events will be Dr. George T. Harrell of Timonium, Maryland, the founding dean of UF's College of Medicine. Dean Harrell came to the UF campus in the early 1950's and joined the late Dr. J. Hillis Miller, in laying the groundwork for the Health Center. Dr. Harrell played a leading role in seeking the initial state appropriation of $5 million for building the Colleges of Medicine and Nursing, which opened in 1956 as the first components of the Health Center. He then directed the medical college through its first decade of development.

Dean Harrell made lasting contributions to the College of Medicine in formulating its early goals, charting its long-range directions, and helping to design a physical plant that would reflect the school's philosophy. When he left UF in 1964, he accepted a similar challenge at Pennsylvania State University where he founded the College of Medicine and became founding provost of the Milton S. Hershey Medical Center. Retired in 1973, he has served as a consultant to medical schools in many parts of the world.

In recognition of his notable contributions to the development of UF's medical college and to the general advancement of medical education, Dr. Harrell will be presented with a Distinguished Service Award by Dr. William Deal, dean of the college.

Featured alumni speakers will be Dr. V. Rod Hentz, graduate of the class of 1968, now an associate professor of surgery at Stanford University Hospital, Stanford, California; Dr. Warren E. Ross, class of 1973, now associate professor of pharmacology and medicine at UF's College of Medicine; and Dr. Mark Steven Gold, class of 1975, now director of research at the Fair Oaks Hospital and director of research at the Psychiatric Diagnostic Laboratories of America in Summit, New Jersey.

Finalizing the anniversary plans is a committee chaired by Dr. Jerome Modell, professor and chairman of the Department of Anesthesiology. Working with him are Dr. J. Lee Dockery, associate dean of the College of Medicine and President of the Florida Medical Association; Dr. Hugh M. Hill, professor of obstetrics and gynecology and associate dean for student and alumni affairs; Dr. Craig S. Kitchens, UF graduate, 1970, now an associate professor of medicine in hematology and oncology; Hazel Donegan, recently retired assistant registrar with the medical college; Dianna Cuppy, director of medical alumni; Arline Dishong, director of Health Center Communications; and Dr. D. Orvin Jenkins, UF alumus, 1968, now practicing as a general surgeon in Gainesville and past president of the UF Medical Alumni Association.

110th ANNUAL MEETING

Scientific program complete

The Florida Medical Association Committee on Medical Education has completed plans for the Scientific Program of the 110th Annual Meeting. Headling the program will be an FMA sponsored symposium on "The Health of the Public" Friday morning, May 4th, featuring Edward N. Brandt, M.D., Assistant Secretary, Department of Health and Human Services (HHS); James Mason, M.D., Director, Center for Disease Control, and J. Lee Dockery, M.D., President, Florida Medical Association. The program will be moderated by Henry M. Yonge, M.D., Chairman, FMA Council on Scientific Activities. Calvin W. Martin, M.D., Chairman of the Committee on Medical Education and Orris O. Rollie, M.D., Chairman of the Subcommittee on the Annual Meeting Scientific Program extend their appreciation to all specialty societies who have contributed to this year's excellent scientific program.

As in the past, 20 hours of AMA Category I CME credits will be available to program registrants. See you at the Palace Hotel, Lake Buena Vista, May 2-6, 1984.

SECTION ON ALLERGY AND IMMUNOLOGY

(Co-sponsored by Florida Allergy Society)
Saturday, May 5, 1984—8:25 a.m. to 12:45 p.m.
Norman H. Wasserman, M.D., Plantation
Program Chairman

"**Drug Allergy,**" Roger W. Fox, M.D., Assistant Professor of Medicine, Division of Allergy and Immunology, University of South Florida College of Medicine, Tampa

"**The Role of Calcium Blockers in Bronchial Asthma,**" Adam Wanner, M.D., Professor of Medicine, Chief, Pulmonary Division, University of Miami School of Medicine, Miami

"**Stinging Insect Allergy — Current Concepts and Controversies,**" Robert E. Reisman, M.D., Clinical Professor of Medicine, State University of New York, Buffalo, New York

"**Role of IgG Antibodies in Human Allergic Disease,**" Robert E. Reisman, M.D.

"**Immunology of Aging,**" John J. Stablein, M.D., Assistant Professor of Medicine, Division of Allergy and Immunology, University of South Florida College of Medicine, Tampa

"Asthma in Pregnancy," Milton Braunstein, M.D., Director of Pulmonary Medicine, Broward General Medical Center, Ft. Lauderdale

"IgG — Subclass Deficiency," R. Lawrence Siegel, M.D., Ph.D., Assistant Professor of Pediatrics and Microbiology-Immunology, Division of Allergy and Immunology, University of South Florida College of Medicine, Tampa

Educational Objectives: Topics will be presented which deal with immunology of aging, drug allergy, the treatment of bronchial asthma, immunologic deficiency, and insect sting allergy. Knowledge gained from these presentations will aid allergists and immunologists in the diagnosis and treatment of allergic and immunologic disorders.

SECTION ON ANESTHESIOLOGY

(Co-sponsored by Florida Society of Anesthesiology)
Friday, May 4, 1984—1:00 p.m. to 5:00 p.m.
Lawrence S. Berman, M.D., Gainesville
Program Chairman

"How to Suitproof Your Anesthetic Practice"

"A Defense Attorney," Leon Handley, Esq., Gurney and Handley, Orlando

"Insurance Perspective," Robert E. White, Jr., Director of Claims and Loss Prevention, Physicians' Protective Trust Fund

Break

"A Plaintiff's Attorney," Stephen Masterson, Esq., Executive Director of the Academy of Florida Trial Lawyers

"An Anesthesiologist's Point of View," J. Stanley McQuade, M.D., Ph.D., LL.D., Lynch Professor of Law, Campbell University School of Lawyers, Buis Creek, North Carolina.

Panel Discussion

Educational Objectives: The objectives of this session are to assist the physician (especially the anesthesiologist) in preventing unwarranted medicolegal cases and responding if a case is brought against him. While practicing good medicine will help decrease the likelihood of loosing a malpractice case, more cases are lost due to poor records than to poor medicine, and these and similar facts will be emphasized.

SECTION ON CHEMICAL DEPENDENCY

(Co-sponsored by Florida Medical Foundation Committee on Impaired Physicians and American Medical Society on Alcoholism)
Thursday, May 3, 1984—1:30 p.m. to 4:30 p.m.
Dolores Morgan, M.D., Miami
Program Chairman

Welcome — Guy T. Selander, M.D., Chairman, FMF Committee on Impaired Physicians

"The Disease Concept of Alcoholism," David L. Ohlms, M.D., Medical Director, St. Anthony Medical Centers, Highland Centers, St. Louis, Missouri; Clinical Director, Weldon Springs Hospital Adolescent Chemical Dependency Unit, St. Charles, Missouri

Break

"Cocaine — The Craze of the 1980s," Charles V. Wetli, M.D., Deputy Chief Medical Examiner of Dade County, and Clinical Associate Professor of Pathology at the University of Miami School of Medicine, Miami

Discussion

Educational Objectives: The educational objective of this program is to broaden the physicians' knowledge of poly drug abuse and its effects on the public.

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Thoracic Society and Florida Chapter, American College of Chest Physicians)
Thursday, May 3, 1984—1:00 p.m. to 5:00 p.m.
Richard G. Connar Jr., M.D., Professor, Chairman, Department of Surgery, University of South Florida College of Medicine, Tampa
Moderator

Mark Snider, M.D., Miami
John R. Ibach Jr., M.D., Jacksonville
Program Chairmen

"Lung Cancer: Current Update"

"Current Trends in Epidemiology of Lung Cancer," William Weiss, M.D., B.A., F.A.C.P., Professor of Medicine, Division of Occupational Medicine, Hahnemann University School of Medicine, Philadelphia, Pennsylvania

"Detection, Diagnosis and Clinical Staging," Allan L. Goldman, M.D., Professor and Director, Division of Pulmonary and Critical Care Medicine, University of South Florida College of Medicine, Tampa

"Surgical Treatment," Edward J. Beattie, M.D., Professor of Surgery, Department of Surgery, University of Miami School of Medicine, Miami

"Radiotherapy," Shyam B. Paryani, M.D., M.S., Radiotherapist, Charles Judson Williams Cancer Treatment Center, Baptist Medical Center, Jacksonville

"Chemotherapy," Oleg S. Selawry, M.D., Medical Oncologist, Miami

Panel Discussion

Educational Objectives: To provide physicians with updated knowledge of the epidemiology, detection, diagnosis, clinical staging and treatment of lung cancer. Surgical, radiotherapy, and chemotherapy treatment will be discussed. At the completion of the program, the attending physician should be able to understand the present state of the art in management of the diagnostic and therapeutic aspects of lung cancer.

SECTION ON CLINICAL ONCOLOGY

(Co-sponsored by Florida Society of Clinical Oncology and Florida Radiologic Society)
Friday, May 4, 1984—1:30 p.m. to 5:30 p.m.
William B. Kremer, M.D., Lakeland
Program Chairman

"Systemic Therapy for Malignant Lymphoma," Roy S. Weiner, M.D., Professor of Medicine, Director of Medical Oncology, University of Florida College of Medicine, Gainesville

"Radio-Therapeutic Approaches to Malignant Lymphoma," Eli Gladstein, M.D., Chief, Radiation Oncology Branch, National Cancer Institute

"Modern Pathology of Malignant Lymphoma," Raul C. Braylan, M.D., Professor of Pathology, University of Florida College of Medicine, Gainesville

"Future Prospectives in the Treatment of Malignant Lymphoma," Gerald E. Elfenbein, M.D., University of Florida College of Medicine, Gainesville

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SECTION ON COLON AND RECTAL SURGERY

(Co-sponsored by Florida Society of Colon and Rectal Surgeons)
Friday, May 4, 1984—1:00 p.m. to 4:15 p.m.
Harvey A. Shub, M.D., Orlando
Program Chairman

"Pubo Rectalis Plications, Sphincteroplasty for Anal Incontinence," Emmet Ferguson Jr., M.D., Jacksonville

"**Silastic Implant for Anal Incontinence,**" Sergio Larach, M.D., Orlando

"**Repair of High Rectal Vaginal Fistulas,**" Nelson Brouillette, M.D., Winter Park

"**Medical Colostomy and Its Use in Repair of Rectal Vaginal Fistulas,**" Harvey Shub, M.D., Orlando

"**Subtotal Colectomy, Rectal Mucousectomy and Ileal-anal Anastomosis,**" Harvey Garber, M.D., Delray Beach

Educational Objectives: The Florida Society of Colon and Rectal Surgeons, noting the need for educating the generic physician as well as the general surgeon in the field of anal rectal surgery, presents four papers of importance not only to the general practitioner but to the general surgeon and gynecologist as well, since the problem of rectal vaginal fistulas is important and must be handled with utmost expertise. A paper will also be included on the new rectal mucousectomy and ileal anal anastomosis which in time may be the operation of choice rather than an ileostomy for inflammatory bowel disease.

SECTION ON DERMATOLOGY

(Co-sponsored by Florida Society of Dermatology)
Friday, May 4, 1984—2:00 p.m. to 5:30 p.m.
Saturday, May 5, 1984—8:30 a.m. to 11:45 a.m.
Sorrel S. Resnik, M.D., Miami
Henry W. Menn, M.D., Miami
Program Chairmen

Friday, May 4

"**Surgical and Non-surgical Pearls,**" (Panel Discussion), Moderator: Sorrel S. Resnik, M.D. Panelists: Hiram Strum, M.D., Atlanta, Georgia; Terrence Cronin, M.D., Melbourne; John Hicks, M.D., Coral Gables; Morris Waisman, M.D., Tampa, and Walter Shelby, M.D., Toledo, Ohio

"**Dermatopathology Clinical Conference,**" Neal Penneys, M.D., Ph.D., Professor, Department of Dermatology and Cutaneous Surgery, University of Miami School of Medicine; Alexander Kowalczyk, M.D., Assistant Professor, Department of Dermatology and Cutaneous Surgery, University of Miami School of Medicine, Miami

Saturday, May 5

"**The Future of Dermatologic Surgery,**" Presidential Address, Sorrel S. Resnik, M.D.

"**Dermatologic Therapy 1984,**"—**Norman Fogel, M.D., Memorial Lectureship,** Walter B. Shelley, M.D., Ph.D., Professor of Dermatology, Medical College of Ohio, Toledo

"**Simulated Mitotic Counts in Patients with Psoriasis Versus Controls,**" M. Joyce Rico, M.D., Second Year Resident, Department of Dermatology and Cutaneous Surgery, University of Miami School of Medicine, Miami

"**Office Axillary Surgery for Treatment of Hidradenitis Suppurativa and Axillary Hyperhidrosis,**"—**Ruth Dugan Memorial Lectureship in Cutaneous Surgery,** Hiram Sturm, M.D., Clinical Professor of Dermatology, Emory University, Atlanta, and President, American Society for Dermatologic Surgery

Break

"**Human T-cell Leukemia Lymphoma Virus,**" Lionel Resnick, M.D., Second Year Resident, Department of Dermatology, Mount Sinai Medical Center, Miami

"**Acne Arthritis — Clinical Manifestations, HLA Antigens and Circulating Immune Complexes,**" Teresa Pullara, M.D., Second Year Resident, Department of Dermatology, University of South Florida College of Medicine, Tampa

"**The Clinical and Serological Manifestations of Lupus Erythematosus,**"—**Wiley Sams, M.D., Lectureship,** W. Mitchell Sams Jr., M.D., Professor and Chairman, Department of Dermatology, University of Alabama, Birmingham

Educational Objectives: Physicians will attain knowledge of new treatments in clinical and surgical dermatological disease. There will also be a presentation on research related to viral diseases and psoriasis.

SECTION ON DIABETES

(Co-sponsored by American Diabetes Association, Florida Affiliate and Florida Endocrine Society)
Thursday, May 3, 1984—1:00 p.m. to 5:30 p.m.
Edward Biederman, M.D., Ft. Lauderdale
Program Chairman

"**Pathophysiology Update,**" Harold E. Lebovitz, M.D., Professor of Medicine, Chief of Endocrinology, S.U.N.Y. Downstate Medical Center, Brooklyn, New York

"**Diabetic Therapy in 1984,**" Harold E. Lebovitz, M.D.

"**Diabetes in Pregnancy,**" Kay F. MacFarland, M.D., Professor of Medicine, Associate Dean of Continuing Medical Education, University of South Carolina School of Medicine, Columbia, South Carolina

"**Diabetic Eye Disease,**" Guy O'Grady, M.D., Chief of Ophthalmology, Miami Veterans Medical Center, Associate Professor of Ophthalmology, University of Miami School of Medicine, Miami

Panel Discussion

Educational Objectives: To enable the primary care physician to assist patients with diabetes mellitus and minimize the chronic complications of this disease.

SECTION ON ENDOCRINOLOGY

(Co-sponsored by Florida Endocrine Society)
Friday, May 4, 1984—1:00 p.m. to 5:00 p.m.
Samuel E. Crockett, M.D., Orlando
Program Chairman

"**Thyroid Biopsies and Thyroid Cancer,**" Joel I. Hamburger, M.D., FACP

"**The Use of Thyroid Biopsy in Private Practice in Florida,**" Jack Baskin, M.D., Orlando

Break

"**Thyroid Lymphoma,**" Joel I. Hamburger, M.D., FACP

Panel Discussion

Educational Objectives: The objective is to enable the physician to provide quality care in the diagnosis and treatment of thyroid cancer and lymphoma.

SECTION ON FAMILY MEDICINE

(Co-sponsored by Florida Academy of Family Physicians)
Thursday, May 3—1:30 p.m. to 4:15 p.m.
Joseph E. Holland, M.D., Leesburg
Program Chairman

"**Toxic Environmental Substances and Concerns of Their Effects on Public Health,**" John E. Davies, M.D., Professor and Chairman, Department of Epidemiology and Public Health, University of Miami School of Medicine, Miami

"**Histamine Blockers,**" Arvey I. Rogers, M.D., Professor of Medicine, University of Miami School of Medicine, Miami

"**Snake Bites,**" T. Byron Thames, M.D., Practicing Family Physician and FMA Past President, Orlando

"**Medical Dissolution of Cholesterol Gallstones,**" Eugene Schiff, M.D., Professor of Medicine, Chief, Division of Hepatology, Coordinator for Liver Diseases, University of Miami School of Medicine, Miami

Educational Objectives: The objective is to provide the practicing physician with updated information on diagnosis, treatment and follow-up on a variety of medical conditions usually seen in the primary care physician's office.

SECTION ON GASTROENTEROLOGY

(Co-sponsored by Florida Gastroenterologic Society)
Friday, May 4, 1984—7:30 a.m. to 9:00 a.m.
Jeffrey A. Diamond, M.D., Hollywood
Program Chairman

"Travelers' Diarrhea," Brad Sack, M.D., Department of Infectious Disease, Johns Hopkins University, School of Medicine, Baltimore, Maryland

"Gastrointestinal Laparoscopy," Jeffrey A. Diamond, M.D., F.A.C.G., Clinical Associate Professor, University of Miami School of Medicine, Miami

"ERCP, Sphincterotomy and Stents," H. David Shifrin, M.D., F.A.C.P., F.A.C.G., Clinical Associate Professor, University of Miami School of Medicine, Miami

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SECTION ON INTERNAL MEDICINE

(Co-sponsored by American College of Physicians, Florida Region and Florida Society of Internal Medicine)
Wednesday, May 2, 1984—1:00 p.m. to 4:15 p.m.
Roy H. Behnke, M.D., FACP, Tampa
Program Chairman

1983 and Beyond: Therapy of Common Medical Disorders

"Respiratory Disease Management," Allan L. Goldman, M.D., Professor of Medicine and Director, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine, University of South Florida College of Medicine, Tampa

"Antibiotic Management," Charles P. Craig, M.D., Professor of Medicine and Director, Division of Infectious and Tropical Diseases, Department of Internal Medicine, University of South Florida College of Medicine, Tampa

Discussion

"Cardiologic Problem Management," Stephen P. Glasser, M.D., Professor of Medicine and Director, Division of Cardiology, Department of Internal Medicine, University of South Florida College of Medicine, Tampa

"Rheumatologic Disease Management," Bernard F. Germain, M.D., Associate Professor of Medicine and Director, Division of Rheumatology, Department of Internal Medicine, University of South Florida College of Medicine, Tampa

Discussion

Educational Objectives: The objective of this program is to highlight the most advanced treatment modalities in four broad areas of common medical disorders, citing their advantages and disadvantages. There will be, in addition, an endeavor to project the drugs and regimens of the future to which primary care physicians can look with some immediate or near immediate expectations.

SECTION ON NEPHROLOGY

(Co-sponsored by the Florida Society of Nephrology)
Thursday, May 3, 1984—1:00 p.m. to 5:30 p.m.
Thomas Marbury, M.D., Orlando
Program Chairman

"Future Renal Transplantation," Dana L. Schires, M.D., Chief of Nephrology, University of South Florida, Tampa

"Early Diagnosis of Renal Disease in Children," Edward Root, M.D., Associate Professor of Nephrology, University of South Florida, Tampa

Break

"Hypertension," Thomas C. Marbury, M.D., Chief of Nephrology, Orlando Regional Medical Center, Orlando

"What's New in Dialysis — Is CAPD the Answer?" Gary Hansen, M.D., Private Practitioner, Tallahassee

Panel Discussion

Educational Objectives: To inform the general physician and internist of updates on high blood pressure, renal disease, dialysis and transplantation.

SECTION ON NEUROSURGERY

(Co-sponsored by Florida Neurosurgical Society and Florida Neurology Society)
Saturday, May 5, 1984-8:30 a.m. to 10:30 a.m.
Arthur L. Day, M.D., Gainesville
Program Chairman

"ICU Management of the Neurosurgical Patient"

"Head Injury and ICP," P. Villanueva, M.D.

"Spinal Injury," Barth A. Green, M.D., Associate Professor, Department of Neurosurgery, University of Miami School of Medicine, Miami

"Subarachnoid Hemorrhage and Vasospasm," Arthur L. Day, M.D., Associate Professor, Department of Neurosurgery, University of Miami School of Medicine, Miami

"Evoked Potential Monitoring," William A. Friedman, M.D., Assistant Professor, Department of Neurosurgery, University of Florida College of Medicine, Gainesville.

Educational Objectives: An update will be provided for the neurosurgeon on the latest techniques and methods of management of the acutely ill neurosurgical patient.

SECTION ON NUCLEAR MEDICINE

(Co-sponsored by Florida Association of Nuclear Physicians)
Saturday, May 5, 1984—9:00 a.m. to 12:00 p.m.
Faith E. Block, M.D., Miami
Program Chairman

"Nuclear Magnetic Resonance (NMR) Imaging"

"Physical Principles and Instrumentation of Nuclear Magnetic Resonance," C. Leon Partain, M.D., Ph.D., Associate Professor of Radiology and Biomedical Engineering; Director of Nuclear Medicine and the NMR Project, Vanderbilt University Medical Center, Nashville, Tennessee

"Initial Clinical Experience in 650 Cases," C. Leon Partain, M.D., Ph.D.

Break

"Clinical Applications of NMR Imaging: An Overview," Robert Kagan, M.D., President, Florida Association of Nuclear Physicians; Director, Northeast Medical Center and the NMR Center of Ft. Lauderdale; Assistant Professor of Radiology, University of Miami School of Medicine, Miami

Educational Objectives: To promote better understanding of the principles and clinical applications of a new frontier in diagnostic imaging; i.e. Nuclear Magnetic Resonance (NMR) Imaging.

SECTION ON OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Obstetric and Gynecologic Society)
Saturday, May 5, 1984—8:00 a.m. to 12:00 p.m.
F. Lee Howington, M.D., Ft. Myers
Program Chairman

"Placenta Previa — The Natural History," Anthony R. Lai, M.D., Miami

"Cervical Lymphoma," Richard C. Mann, M.D., Tampa

"The Relationship of Serum Magnesium Levels and Urine Output," Christine A. Penso, M.D., Miami

"Management of Fetal Complete Heart Block in Labor," Jeffery L. Angel, M.D., Tampa

Break

"Rhabdomyosarcoma of the Vulva," Jeffrey Bell, M.D., Miami
"Experience with the Use of Prostaglandin Gel for Rippening of the Cervix," J.K. Williams, M.D., Tampa
"Heterotopic Triplet Pregnancy Following Tubal Reanastomosis and Ovulation Induction," Karen H. Brown, M.D. and Frank C. Riggall, M.D., Gainesville
Premature Labor, Tocolytic Agents, Steroids, and Pulmonary Edema," Walter J. Morales, M.D., Orlando
"Accuracy of Stated Last Menstrual Period — 5,000 Cases," Sam Barr, M.D., Winter Park

Educational Objectives: The objective is to impart information to our members on topics which are current and applicable to their practice of obstetrics and gynecology.

SECTION ON OCCUPATIONAL MEDICINE

(Co-sponsored by Florida Occupational Medical Association)
Friday, May 4, 1984 — 1:00 p.m. to 5:00 p.m.
Maurie Pressman, M.D., Clearwater
Program Chairman

"Honeywell's Program for Health Care Management," John Burns, M.D., Medical Director, Honeywell, Inc., Minneapolis, Minnesota
"On Housing Health, Safety and Employee Assistance in the Same Organizational Department — The Johnson & Johnson Experience," Ken Krieger, Director, Department of Health and Safety, Critikon, Inc., Tampa
"Joining Health and Mental Health Prevention: Employee Enhancement Programs," David E. Stenmark, Ph.D., Behavioral Medicine, Intervention Systems, Clearwater
"Occupational Stress: Identification and Management," Emmett B. Ferguson, M.D., Medical Director, Occupational Medicine, Environmental Health Services, Kennedy Space Center, Florida

Educational Objectives: The objective is to provide an examination of occupational medicine issues encompassing health care cost management, occupational stress identification and management, and the release of employee potential. These often neglected topics are designed to assist occupational medicine professionals to more effectively address medical problems relating to the work environment.

SECTION ON OPHTHALMOLOGY

(Co-sponsored by Florida Society of Ophthalmology, Inc.)
Friday, May 4, 1984 — 1:00 p.m. to 5:00 p.m.
Saturday, May 5, 1984 — 8:30 a.m. to 12:30 p.m.
Harry W. Flynn Jr., M.D., Miami
Program Chairman

Friday, May 4

"Management of Dislocated Lens Fragments," Harry W. Flynn Jr., M.D., Miami
"Microbial Keratitis," Richard L. Abbott, M.D.
"An Approach to the Patient with Orbital Disease," Joel S. Glaser, M.D.
"Ocular Manifestations of Dermatologic Disease," Richard L. Abbott, M.D.
Break
"Common Optic Nerve Disease," Joel S. Glaser, M.D.,
"Macular Disease in Diabetic Patients," Frederick L. Ferris, M.D.
"Macular Degeneration — A Treatable Disease," Robert P. Murphy, M.D.
"Management of Acquired Ptosis," Lawrence B. Katzen, M.D.

Saturday, May 5

"Infectious Diseases of the Retina I," William W. Culbertson, M.D.
"Infectious Diseases of the Retina II," Mark Blumenkranz, M.D.
"Application of DRS Data to Clinical Practice," Frederick L. Ferris, M.D.
Break
"Common Macular Disease," Robert P. Murphy, M.D.
"Common Uveitis Problems," William W. Culbertson, M.D.
"Advances in Vitreo-Retinal Microsurgery," Mark S. Blumenkranz, M.D.
"Management of Intraocular Foreign Bodies," Harry W. Flynn Jr., M.D.

SECTION ON ORTHOPEDICS

(Co-sponsored by Florida Orthopaedic Society)
Thursday, May 3, 1984 — 1:00 p.m. to 5:30 p.m.
Friday, May 4, 1984 — 7:00 a.m. to 9:00 a.m.
Saturday, May 5, 1984 — 8:00 a.m. to 10:30 a.m.
William Petty, M.D., Gainesville
Program Chairman

Thursday, May 3

"Maintenance of Musculoskeletal Health — Children," Richard E. King, M.D., Chief of Orthopaedic Surgery, Georgia Baptist Medical Center, Atlanta, Georgia
"Maintenance of Musculoskeletal Health — Adult," Richard E. King, M.D.

Friday, May 4

"Quality Care and Cost Issues," Richard E. King, M.D.

Saturday, May 5

"General Scientific Session," Richard E. King, M.D.

Educational Objectives: The objective is to provide the practicing orthopaedic surgeon with updated information regarding practical advances in the field of orthopaedic surgery. Submitted abstracts have been carefully reviewed by the Program Chairman and papers for presentation were selected on the basis of their educational value.

SECTION ON PATHOLOGY

(Co-sponsored by Florida Society of Pathologists)
Friday, May 4, 1984 — 2:00 p.m. to 5:00 p.m.
Gert G. Larbig, M.D., West Palm Beach
Program Chairman

"Cost Effective Laboratory Utilization Under the DRG Prospective Payment System," George D. Lundberg, M.D., Professor of Clinical Pathology, Northwestern University, Chicago; and Editor, *Journal of the American Medical Association*
Break
Presentation of Awards of Florida Society of Pathologists
"Contributions of the Medical Examiner System to Florida's Public Health," Wallace Graves Jr., M.D., Chairman, Florida Medical Examiners' Commission, Fort Myers

Educational Objectives: As the Medicare DRG Prospective Payment System is phased in, it is imperative that the practicing physician become knowledgeable on the cost of laboratory tests and how to use them in a cost effective manner. In conjunction with this year's theme, "The Health of the Public," the importance of the Medical Examiner will be illustrated.

SECTION ON PEDIATRIC CARDIOLOGY

(Co-sponsored by Florida Association of Pediatric Cardiologists)
Saturday, May 5, 1984 — 8:30 a.m. to 11:30 a.m.
Michael L. Epstein, M.D., Gainesville
Program Chairman

Updated Pediatric Cardiology 1984

Participants: Edward Bayne, M.D., Clinical Assistant Professor of Pediatrics, Jacksonville Hospitals Education Program; William Blanchard, M.D., Clinical Assistant Professor of Pediatrics, University of Florida College of Medicine and Associate Director of Pensacola Medical Education Program; James Henry, M.D., Clinical Assistant Professor of Pediatrics, University of South Florida College of Medicine; Arthur Pickoff, M.D., Associate Professor of Pediatrics, University of Miami School of Medicine; Arthur Raptoulis, M.D., Clinical Associate Professor of Pediatrics, University of Florida College of Medicine and Chief Division of Pediatric Cardiology, Orlando Regional Medical Center; Benjamin Victorica, M.D., Professor of Pediatrics, University of Florida College of Medicine; James Alexander, M.D., Professor of Surgery and Chief of Division of Cardio-Thoracic Surgery, University of Florida College of Medicine

Educational Objectives: The objective is to enable pediatricians and pediatric cardiologists caring for children with heart disease in Florida to present difficult diagnosis and/or therapeutic problems to a panel of cardiologists and surgeons experienced in the medical and surgical aspects of children with complex heart disease. Specific cases will be presented by individual participants and time will be scheduled for discussion of the various aspects of each case. In addition, time will be allowed for discussion of cases brought by pediatricians and other cardiologists throughout the state which may present a particularly difficult dilemma for the primary care physician.

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

(Co-sponsored by Florida Society of Physical Medicine and Rehabilitation)
Saturday, May 5, 1984—9:00 a.m. to 11:45 a.m.
Luis de Lerma, M.D., St. Petersburg
Program Chairman

"The Rehabilitation and Management of Patients Undergoing Total Hip Replacement," J.R. de Andrade, M.D., Department of Orthopaedics, Emory University School of Medicine, Atlanta, Georgia

Break

"Diagnostic Related Groups — Their Impact on Private Practice," A.J. Pasach, M.D., Pasach, Eichberg and Parada Professional Association, Tampa

Educational Objectives: To study, analyze and make suggestions on various topics involving physical medicine and rehabilitation.

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY

(Co-sponsored by Florida Society of Plastic and Reconstructive Surgeons)
Saturday, May 5, 1984—8:00 a.m. to 11:00 a.m.
M. Felix Freshwater, M.D., Miami
Program Chairman

"Eyelid and Adnexal Reconstruction," James H. Carraway, M.D., Professor of Plastic Surgery, Eastern Virginia University School of Medicine, Norfolk, Virginia

"Rational Approach to Soft Tissue Coverage of the Lower Extremity," M. Felix Freshwater, M.D., Assistant Professor of Plastic Surgery, University of Miami School of Medicine, Miami

SECTION ON PSYCHIATRY

(Co-sponsored by Council of Florida District Branches of the American Psychiatric Association and The Public Information Committee of the Florida Psychiatry Association)
Saturday, May 5, 1984—9:00 a.m. to 12:00 p.m.
McKinley Cheshire, M.D., West Palm Beach
Program Chairman

"Psychological Changes of Physicians as They Reach Retirement Age," Robert G. Steele, M.D., Fellow, American Psychiatric Association, Sarasota

"Underutilization of Retired Physicians," Samuel R. Warson, M.D., Life Fellow, American Psychiatric Association, Sarasota

"On Being a Medical Doctor," McKinley Cheshire, M.D., Past President and Director of Public Information, Florida Psychiatric Society, West Palm Beach

Break

"Assessing the Psycho-socio Biology of Mental Health — The Strain Ratio," Richard E. Gordon, M.D., Life Fellow, Florida Psychiatric Society; Editor, *Bulletin of Southern Psychiatry*

Educational Objectives: The objective is to present information on physician lifestyles which may contribute toward avoiding impairment, including strategies on how to assess the degree of mental illness. Special invitations are extended to physician spouses and their attendance is encouraged.

SECTION ON PREVENTIVE MEDICINE

(Co-sponsored by Florida Society of Preventive Medicine)
Saturday, May 5, 1984—9:00 a.m. to 12:00 p.m.
Robert K. Wilson, M.D., Pensacola
Robert D. May, M.D., New Port Richey
Program Chairmen

Greetings from the Program Chairmen

"State of the Public's Health," Stephen King, M.D., Staff Director, Health Program Office and State Health Officer

"Financial Strategies for Health Services," James Howell, M.D., Deputy Secretary, Department of HRS, Tallahassee

"Practical Guide to Nutrition," Thomas E. Grow, Ph.D., Associate Professor, Department of Basic Dental Science, University of Florida College of Medicine, Gainesville

Break

"Infectious Disease Update," John Witte, M.D., M.P.H., Program Administrator, Preventive Health Services, Department of HRS

"The Impact of the Florida Drunk Driving and Child Restraint Laws on the Health of the Public," Sergeant Robert M. Kirby, Public Information, Safety Education Office, Florida Highway Patrol

"What a Piece of Work is Man" Major Public Health and Preventive Medicine Issues in USA Today, (Slide Presentation), Robert May, M.D. and Ray Cowart, M.D.

Educational Objectives: The objective is to promote the positive aspects and contributions of public health through a series of updates and presentations by leaders in the field of preventive medicine.

SECTION ON RADIOLOGY

(Co-sponsored by Florida Radiologic Society, Inc.)
Friday, May 4, 1984—1:00 p.m. to 4:45 p.m.
Saturday, May 5, 1984—7:00 a.m. to 5:00 p.m.
Sylvan Sarasohn, M.D., Miami
Thomas Thompson,M.D., Miami
Program Chairmen

Friday, May 4

"Radiologic Equipment Selection, Purchase and Maintenance," Thomas Thompson, M.D., Chairman of Equipment and Facilities, Department of Radiology, University of Miami, Miami

Break

Continuation of above seminar

Saturday, May 5

Continental Breakfast

"Percutaneous Removal of Kidney Stones," James Caridi, M.D., Resident-Fellow, The J. Hillis Miller Health Center, University of Florida, Gainesville

"Percutaneous Uses of Absolute Alcohol," Gregg S. Nanni, M.D., Resident-Fellow, The J. Hillis Miller Health Center, University of Florida, Gainesville

"Percutaneous Biliary System Decompression," David M. Pearse, M.D., Resident-Fellow, The J. Hillis Miller Health Center, University of Florida, Gainesville

Break

"C.T. Discography," Jim Barnes, M.D., Resident-Fellow, Medical Center, University of Florida, Gainesville

"Neonatal Head Ultrasound," Eve Jehle, M.D., Resident-Fellow, Medical Center, University of Florida, Gainesville

"Chemodactomas," Norm Clinkscales, M.D., Resident-Fellow, Medical Center, University of Florida, Gainesville

Buffet Luncheon

"Legal Aspects on Radiological Practice," Joan Wollin, Attorney at Law

Break

"Resident's Workshop — Socioeconomic Aspects of Radiological Practice," Sylvan Sarasohn, M.D., Past President, Florida Radiological Society

Educational Objectives: To educate radiologists in the capability and limitations of imaging equipment. Because there is increasing interest among radiologists for interventional procedures, summaries of the aspects of newer interventional techniques will be presented on Saturday morning. Topics on the socioeconomic aspects of radiological practice will also be discussed.

SECTION ON RHEUMATOLOGY

(Co-sponsored by Florida Rheumatology Society)
Thursday, May 3, 1984 — 1:30 p.m. to 5:00 p.m.
M.F. Mass, M.D., Jacksonville
Program Chairman

"Arthritis in Childhood," Jerry C. Jacobs, M.D., Professor of Clinical Pediatrics, Director, Pediatric Rheumatology, Columbia University, New York

"Kawasaki Disease," Jerry C. Jacobs, M.D.

"Update on AIDS," N. Lawrence Edwards, M.D., Assistant Professor of Medicine, University of Florida, Gainesville

Educational Objectives: The objective will be to provide current information and review to enable practicing physicians to provide quality care in the treatment of arthritis in children, Kawasaki's Disease, and AIDS.

SECTION ON SURGERY

(Co-sponsored by Florida Chapter, American College of Surgeons and Florida Association of General Surgeons)
Friday, May 4, 1984 — 2:00 p.m. to 5:00 p.m.
David H. Shapiro, M.D., Belleair
William Hartley, M.D., Ft. Lauderdale
Program Chairmen

"Socio-Economic Issues in Medicine"

"Prospective Pricing and Physicians," Donald Young, M.D., Executive Director, Prospective Payment Assessment Commission, Health Care Financing Administration

"Prospective Reimbursement and Physicians," Richard C. Dever, M.D., Medical Director and Vice President, Medical Affairs, Blue Cross/Blue Shield of Florida

"Changing Practice Environment," James Haug, Director, Department of Surgical Practice, American College of Surgeons

"HMOs and PPOs — The Florida Scene," Harvey Matoren, Vice President, Alternative Delivery Systems, Blue Cross/Blue Shield of Florida

Resident Paper Competition

Presentation of winning scientific papers from resident physicians

Panel Discussion

Educational Objectives: Governments, state and local, are all looking for ways to control health care spending and to hold down the cost for government-sponsored health care programs. Employers have become extremely concerned with the escalating cost of medical care and are looking for ways to hold down their costs to provide health care coverage for their employees. This has caused an increased emphasis on competition in health care and it is important that physicians comprehend the mechanisms and methods that will impact the future of health care delivery. The objective of this program is to advise physicians of some of these influences and to prepare them for the changing practice environment.

SECTION ON SURGERY

(Co-sponsored by International College of Surgeons)
Saturday, May 5, 1984 — 10:00 a.m. to 12:00 p.m.
Robert H. Hux, M.D., Leesburg
Program Chairman

"Evaluation of the Trauma Patient," David L. Sustarsic, M.D., Lieutenant Commander, U.S. Naval Reserve, Medical Corp., U.S. Naval Reserve, Chief of Surgery, U.S. Naval Hospital, Lemoore, California, Instructor in Advanced Trauma Life Support

Educational Objectives: The objective is to assist physicians and surgeons in evaluating the trauma patient presenting in the hospital emergency room. The basis, knowledge and skills necessary to identify patients needing rapid assessment, resuscitation, stabilization and possible transfer will be presented. A method of immediate management will be presented and a base provided upon which a physician may build knowledge and skills in trauma management as the Advanced Cardiac Life Support program has done for physicians in general.

SECTION ON THORACIC AND CARDIOVASCULAR SURGERY

(Co-sponsored by Florida Society of Thoracic and Cardiovascular Surgeons)
Saturday, May 5, 1984 — 8:00 a.m. to 11:00 a.m.
James A. Alexander, M.D., Gainesville
Program Chairman

"State of the Art — Myocardial Protection," Robert A. Guyton, M.D., Assistant Professor of Surgery, Emory University, Atlanta, Georgia

"Individual Use of Cardioplegia with Case Presentations of Long Ischemic Time," Richard Perryman, M.D., Jacksonville; Ernest Traad, M.D., Miami; Dennis Pupello, M.D., Tampa; Gordon Moor, M.D., Lakeland, and James A. Alexander, M.D., Gainesville

Discussion

Educational Objectives: The educational objective will be to apply the latest up-to-date methods in the management of myocardial protection.

DIALOGUE

(Presented through the Courtesy of Pfizer Laboratories)
Thursday, May 3, 1984—1:00 p.m. to 4:30 p.m.
Great Hall East

(Note: In each Dialogue segment, the guest makes an opening statement of 5-10 minutes, and the remainder of the hour is devoted to questions and answers about the topic.)

Somatic Manifestations of Depression," Joseph Talley, M.D., Clinical Associate Professor, Department of Family Medicine, University of North Carolina School of Medicine, Chapel Hill, North Carolina

"Mixed Angina," Alan B. Miller, M.D., Associate Professor of Medicine, University of Florida College of Medicine; Chief, Division of Cardiology, University Hospital, Jacksonville

"Alternative Health Care Systems," William J. Garoni Jr., M.D., Chairman, Committee on Health Care Financing, Florida Medical Association, Jacksonville

DEAN'S MESSAGE

6,000 Auxilians, thank you

In every successful venture, there are generally four types of participants: (1) the leadership, which may be one person or a small group, (2) the large group of people who are involved and active, (3) a group who do little but frequently complain and criticize, and (4) those who facilitate, support, and form the matrix of the organization.

Before the reader decides which classification is applicable, it is important to caution that unless the reader is a member of the Auxiliary, the latter classification does not apply. For it is the Auxiliary that provides the Florida Medical Association the requisite standard of excellence through their constant support and work.

Through their activities this year, over $100,000 has been raised for the American Medical Association Education and Research Foundation. These monies will be used principally for support of medical education through either student aid or direct grants to medical schools. The direct grants to the medical schools are unrestricted in nature and provide the Deans with an aliquot of flexible money.

These monies are used almost exclusively to assist and support our younger colleagues — medical students.

Through the dedicated and directed energetic activities of the Auxiliary, your medical schools are better institutions.

Every member of our Association gives thanksgiving to the 6,000 members of the Florida Medical Association Auxiliary.

William B. Deal, M.D., Dean
College of Medicine
Associate Vice President
for Clinical Affairs
University of Florida

WORTH REPEATING

Tobacco Addiction and other drug abuse among American youth

By every important measure of addiction — psychoactive effects, habitual use leading to dependence and compulsive abuse, physiological and psychological distress upon discontinuance, and a tendency to recidivism — tobacco smoking is addictive. In fact, when measured by morbidity and mortality, cigarette smoking is now probably the most serious as well as the most wide-spread form of addiction in the world. In the U.S., there are 56 million current cigarette smokers and more than 350,000 excess deaths per annum from smoking — approximately 1,000 tobacco deaths per day.

With no other drug do people so busy themselves with administering it as they do in the case of cigarettes. In an 18-hour waking day, a two-pack-a-day smoker spends from three to four hours with a cigarette in mouth, hand, or ashtray, takes about 400 puffs for the day, and inhales up to 1,000 milligrams of tar.

Cigarette smoking has been found by the National Institute on Drug Abuse to be a form of drug dependence. This conclusion is supported by the United States Public Health Service, and is also the position taken by the World Health Organization, the American Psychiatric Association, and the internationally recognized Committee on Problems of Drug Dependence.

Not only is cigarette smoking itself a most serious form of drug abuse, but because of its legal status and the general availability of cigarettes, cigarette smoking serves as a 'gateway' to the use of other psychoactive drugs. Cigarette smokers are much more likely to use marijuana, alcohol, cocaine/hallucinogens/heroin than nonsmokers. While it is unlikely that these great differences in

drug abuse by smokers and nonsmokers are mainly caused by cigarette smoking per se, smoking is usually the adolescent's first experience with a psychoactive drug.

There exists a powerful inverse relationship between cigarette smoking and academic achievement. Comprehensive studies of smoking and academic achievement in Seattle high schools during the 60s demonstrated this phenomenon. When the proportion of 12th grade students then or previously regular cigarette smokers was plotted against grouped cumulative grade point averages, a straight line negative correlation was evident for boys, and somewhat less for girls. Three fourths of failing male students were regular cigarette smokers, and almost none of the top students. While it is unlikely that it was smoking per se that caused most of the poor scholastic performance by smokers, it may have contributed thereto. Heavily smoking students may study less effectively because of frequent interruptions of their concentration, because of high blood levels of carbon monoxide, and because of increased respiratory illness.

At the beginning of the 20th century, infectious diseases were the foremost cause of death in the world. But during the last half of this century, diseases caused by abuse of hazardous substances—tobacco, alcohol, cocaine, heroin, etc.—have replaced the infectious diseases as the foremost preventable cause of death in the United States. Tobacco has replaced tuberculosis as the single leading preventable cause of death. Tobacco now kills approximately 200 times as many Americans per annum as tuberculosis — 350,000 deaths in 1981 vs. 1,780 deaths from tuberculosis. And since the First World Conference on Smoking and Health 16 years ago, approximately 5 million Americans have died from smoking.

Finally, one should note that the majority of regular smokers in the United States have developed this behavior pattern during their teen years. Thus, we see that an addiction has become established before the age of either meaningful or legal informed choice. What the legal implications of this might be in terms of advertising practice — i.e., efforts to increase sales and distribution of an addictive agent — and legal liability for those whose addictive behavior has led to major health consequences, remains to be seen.

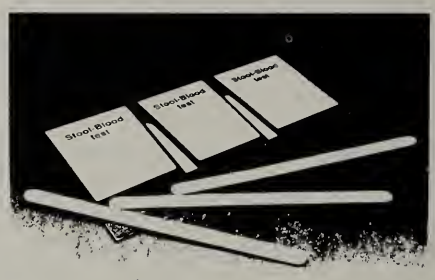
Addictive disorders now cause more than ¼ of all deaths in the U.S. — more than ½ million deaths in 1932.

R.T. Ravenholt, M.D.
Assistant Director for
Epidemiology and Research
William Pollin, M.D.
National Institute on Drug Abuse

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50,000 people will be saved from colorectal cancer this year. You can save one.

Save yourself! Colorectal cancer is the second leading cause of cancer deaths after lung cancer. More than 90% of colorectal cancers occur equally in men and women past age 50. Early detection provides the best hope of cure. That's why if you're over 50, you should take this simple, easy slide test of your stool every year. This Stool Blood Test kit is chemically treated to detect hidden blood in the stool and can be done at the time of your periodic health examination so your doctor will know the results.



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Other tests for colorectal cancer you should talk to your doctor about: digital rectal exam (after age 40); the procto test (after age 50). It is important to report any personal or family history of intestinal polyps or ulcerative colitis, and any change in your bowel habits, which could be a cancer warning signal.

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The visual field manual

By Jonathan O. Trobe, M.D. and Joel S. Glaser, M.D., 224 Pages, 200 illustrations, paperback. Price $17.95. Triad Publishing Co., 1983.

Drs. Trobe and Glaser have written a good book, one primarily for ophthalmic technicians, ophthamologists and ophthamology residents. Neurologists, neurosurgeons, psychologists and others who must refer to, understand or use visual field testing will find it a concise, yet thorough, reference at a bargain price.

This manual moves rapidly through old theories and concepts to modern definitions, techniques, instrumentation and interpretation. It includes "practice" quizzes at the end of each chapter.

The authors stress an overview concept — the "strategy" of field testing. For example, "Why do this particular patient's fields — ? — What is it one suspects? — What is the method or technique to best reveal the lesion or assist in the diagnosis?"

The chapters on "Pitfalls," "Interpretation," and "Testing and Recording" are helpful, clearly written and avoid repetition.

Chapter 8, "Instrumentation" may assist the person considering equipment purchase to make a better informed choice.

Chapter 10, "Problem Cases: Diagnosis" is a stimulating section, a self-testing portion of the book which will increase the diagnostician's confidence and knowledge.

The authors seem to achieve preface-set goals. Fields are often done by a disinterested employee, resident or technician who may not know what the ophthalmologist suspects or what complaints the history contains; they are often done in a routine bored fashion, without review of the patient's previous file and under inconstant or non-standard condition. The authors seek to replace these faults with a higher level of interest, alertness, capability and diagnostic awareness . . . to restore the "art" to one aspect of medicine. To this end they value the "feedback" and interpretive interaction of the human perimetrist over the automated or computer assisted device.

The book is well indexed. It contains but a brief bibliography. We recommend it to all ophthalmic trainees and practitioners.

Nick Kalvin, M.D.
Naples

● Dr. Kalvin is in the private practice of Ophthamology in Naples. He is a Past President of The Florida Society of Ophthamology, a past member of The Board of Councillors of The American Academy of Ophthamology, and finished his residency at The Bascom Palmer Eye Institute in 1966.

FLORIDA MEDICAL ASSOCIATION AUXILIARY, INC.

18TH ANNUAL BENEFIT ART AND CRAFTS SHOW

Thursday, May 3, 8:30-4:30
Friday, May 4, 8:30-4:30
Saturday, May 5, 8:30-Noon

EXHIBIT RULES AND REGULATIONS

Read Rules Carefully

1. All entries must be original work.
2. Pictures must be framed and wired for hanging. (Stands will be provided for sculpture, etc.)
3. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).
4. Only one artist's name should be listed for each registration slip.
5. A registration fee of $10 will be charged for each entry. Entry fees are tax deductible. Entry fees will be donations to AMA-ERF, divided equally among Florida medical schools.
6. All registration slips and checks must be sent in together no later than April 15, 1983.
7. All pre-registered entries are to be delivered by hand to the Exhibit Hall at The Buena Vista Palace Hotel no later than 3:00 p.m., Wednesday, May 2. Shipped entries will be refused.
8. All entries must be picked up noon Saturday, and must be signed out before removal from the show.
9. We will not be responsible for entries not picked up by 12:00 Noon, Saturday, May 5, 1984.
10. Doctors, spouses of doctors and doctors' children are eligible to enter.

Kindly enter my registration to show in the Benefit Art and Crafts Show.

Fee of $_____ for _____ is enclosed. I agree to abide by the rules and regulations for exhibiting material in the show.

Name _____

Address _____

City _____ County _____

I will be showing in the following categories: Please check (X) appropriate category (categories) and division applying to your entry (entries).

Division: (1) Adult _____ (2) Youth _____

Category: ( ) A. Painting. Include any media in color: acrylic, oil, casein, collage, watercolor, pastel, etc.

Size: _____ (H) x _____ (W) To be hung on wall.

( ) B. Graphics. Include a pen and ink, charcoal, photography, etc.

Size: _____ (H) x _____ (W)

( ) C. Crafts. Include sculpture, pottery, ceramics, mosaic, weaving, quilting, handwork, etc.

Size: _____ (L) x _____ (D) x _____ (H)

( ) I am the son/daughter of a Florida physician. Age _____

"Awards of Merit" and "Best in Show" will be judged by experts in art, photography and crafts.

An "Editor's Award," given by *The Journal of the Florida Medical Association, Inc.*, will be used on the cover of a future issue of *The FMA Journal.*

A registration fee of $10 will be charged for each entry. Make checks payable to: FMA-A Art Show, Mrs. Lawrence Wagers, 2932 Westchester Avenue, Orlando, Florida 32803, (305) 898-6359.

Note: It is most important to know the size of your art objects, paintings, etc., to enable us to display them more professionally. We will not be responsible for damage or loss of any entry.

Auxiliary Liaison Editor — **Mrs. L. G. (Mae) White**

The Hasty Family

The Florida Medical Association Auxiliary has given birth to a family known as "The Hasty Family." "H.A.S.T.Y." stands for Health and Safety Tips For You. It was created as a vehicle for the Auxiliary's health education and safety campaign.

"The Hasty Family" is a cartoon strip with story lines revolving around the life and times of a typical family. The cartoon family consists of a complete range of characters, therefore, the story lines will be able to reach all age groups. Many topics of health and safety will be covered. Using a comic strip as a media makes the learning of health and safety tips more pleasurable and hopefully, memorable.

Health coordinators, curriculum directors, and health education supervisors in every county of Florida have been contacted and invited to use "The Hasty Family" cartoon strip in their county educational publications and in the classrooms. Individual coloring sheets are also being designed to coordinate with already existing health education lesson plans. The response has been wonderful. We have been thanked for our cooperation in promoting and expanding awareness in health education. Many newspapers throughout Florida have also been contacted and our own medical societies have been invited to use "HASTY" too. Hopefully this cartoon will soon be seen in many places in Florida.

Janet DelCastillo, an Auxiliary member, was asked to illustrate the HASTY concept. The messages are conveyed through subtle humor. Mrs. DelCastillo, a resident of Winter Haven, is well known in Polk County for her artwork. She is volunteering her time and talent for the HASTY comic strips.

The Auxiliary welcomes any ideas for story lines or ways of marketing our unique product. A Florida pediatrician, Kay K. Hanley, M.D. of Clearwater, suggested developing a coloring book of HASTY messages for pediatricians to give to their patients.

Look for "The Hasty Family" educational display at the FMA Annual Meeting in May and at the Florida School Health Conference which will be held next year.

The Florida Medical Association Auxiliary is proud of our new "Family" and hope that they will become friends of your patients, the citizens of Florida.

Mrs. Priscilla (S. Bruce) Gerber
Winter Haven



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* April 14-21 (from Los Angeles, CA) 7 Day Mexican Riviera

May 19-26 (from Honolulu, HI) 7 Day Hawaiian

* June 30-July 14 (from San Francisco, CA) 14 Day Alaskan
* July 25-Aug. 4 (from Ft. Lauderdale, FL) 10 Day Caribbean

Aug. 11-25 (from Venice, Italy) 14 Day Mediterranean

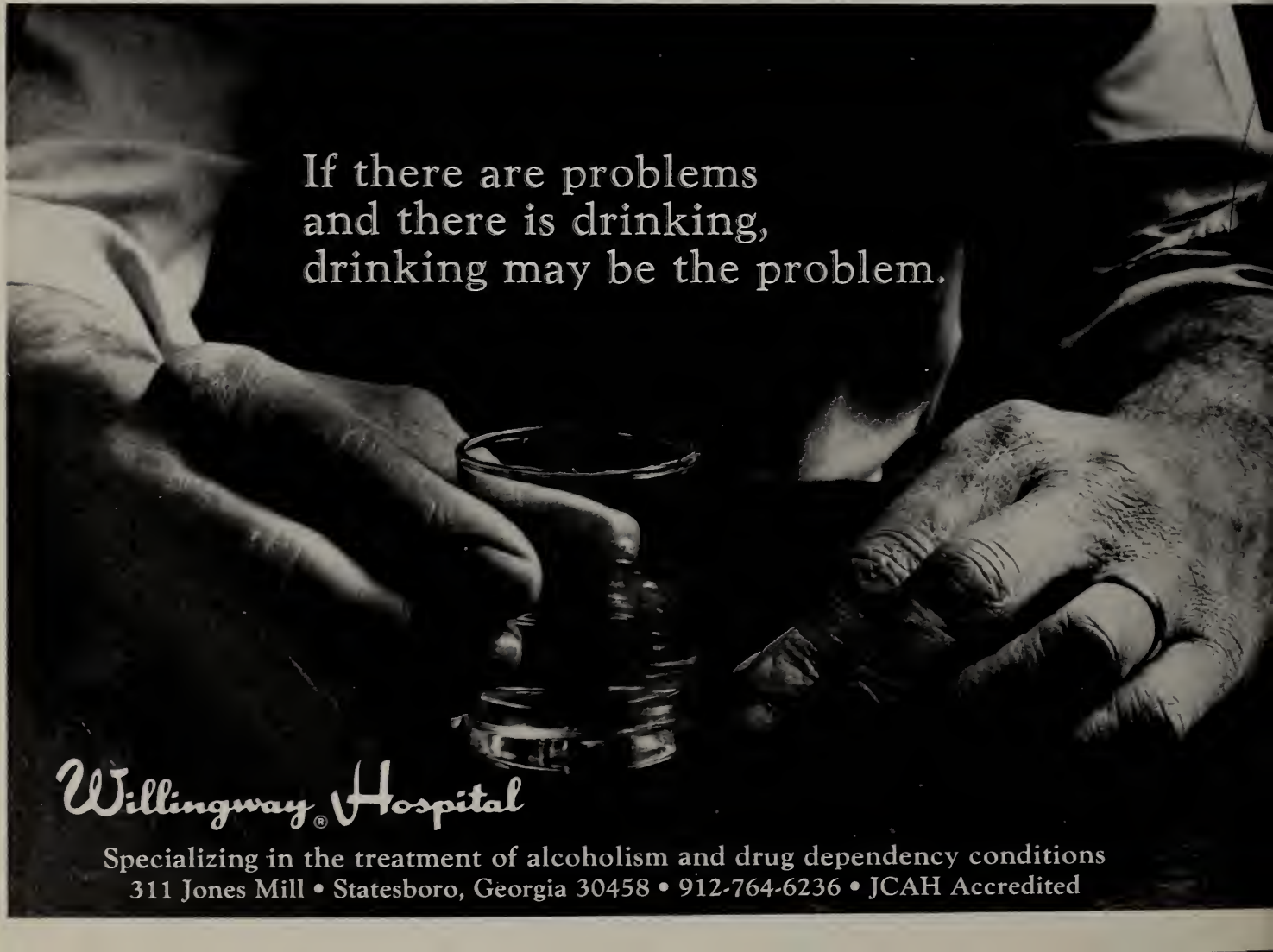
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PRESIDENT'S PAGE

In the days ahead . . .



By the time this will be printed, the Annual Meeting of the Florida Medical Association will have concluded. The reference committees will have deliberated and the House of Delegates will have once again taken actions and established policy to direct the Board of Governors and the various councils and committees of the Association for the next year.

Under the theme, "The Health of the Public," the membership of the Association through its component societies has become involved in a variety of issues. The activity and interest of the membership because of the rapidly escalating medical malpractice problem have never been greater or more united. The statesmanship and high level of professionalism exhibited by the record number of delegates who attended the special meeting of the Florida Medical Association held on January 28, 1984, are qualities of which every member of the Florida Medical Association can take great pride. Through unprecedented action, we will work hard to fulfill our commitment to solve the medical malpractice problem by taking the issue to the public.

We, as physicians, have shown the public we are interested in helping to control the cost of medical care. You are helping to educate the public on the components of the cost of medical care while agreeing to voluntarily "hold the line" on any increases in physicians' fees. Many physicians are contributing valuable free services to the citizens of their community for which we are doing a better job of publicizing.

The competitive initiatives or alternative health care systems have flourished during the past year. You have become better informed and have helped the Association to develop informational materials for the public. Every Florida citizen must be better informed about their choices concerning access to quality health care.

Throughout the 1984 legislative session, the Florida Medical Association will continue to make every effort to oppose attempts by nonphysicians to practice medicine under the disguise of cheaper and more personal care.

To the 435 members who have worked on the various councils and committees of the Florida Medical Association, to the 45 staff members who serve untiringly, and to our spouses in the Auxiliary, we owe a tremendous debt of gratitude for their devoted service throughout this past year. But the final assessment of our health care system is the opinion of our patients, our neighbors, and our friends. In the tough days ahead, let us each rededicate ourselves to the health and welfare of our patients. Let us dust off "the Oath," straighten our backs, adjust our mantles of caring, become vibrant in our spirit, and get back to the kind of "doctoring" the public needs and wants and which we the physicians are the best prepared and most capable.

J Lee Mackenzie

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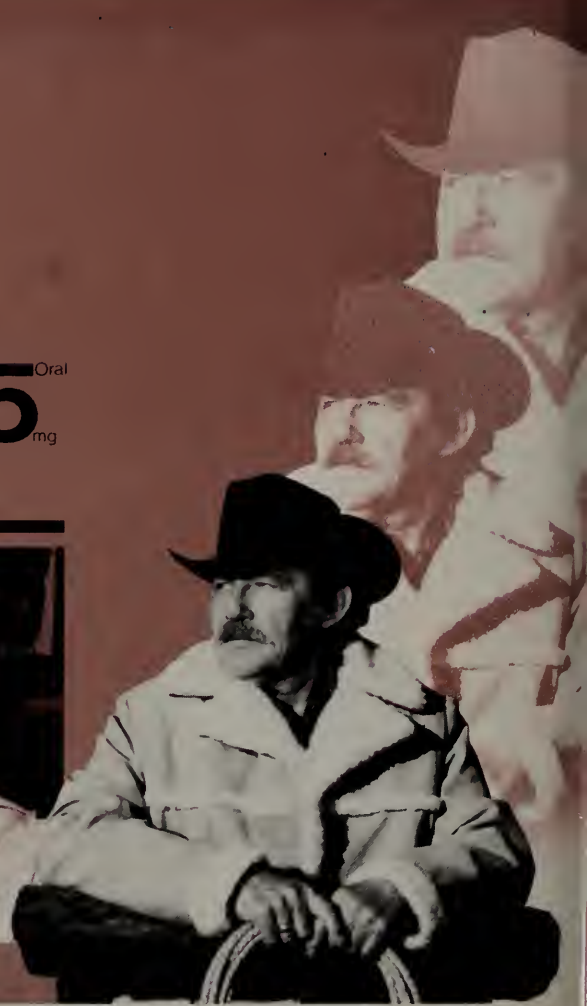
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EDITORIAL

The 110th

Reflecting on the just finished 110th Annual Meeting of the FMA started me speculating. Had I been present at the 1st, what similarities would I have noted? What differences? Obviously that can only be pure speculation but it isn't necessary to go back that far. Suppose I just think back to the 90th. That really can be compared.

Issues vary from era to era but they don't spring out of nowhere and there are no resolutions that make them suddenly disappear. Rather, an issue will quietly tiptoe about for several years, touching down here and touching down there but scarcely demanding attention. Gradually, with a crescendo the pitch and tempo are raised until everyone's attention is claimed. Then the reaction begins and during the ensuing years less and less is heard of it and finally a general accomodation has been reached. From start to finish some aspect of medical practice may have been altered beyond recognition — maybe for the better but also, maybe not.

Although most of these issues arise from without the profession, our leadership is aware of them and attempts to make the membership aware before they become crises. My observation though, has been that the average practicing physician just doesn't listen until the issue touches his or her personal practice. Then the reaction is a stunned, "what happened?"

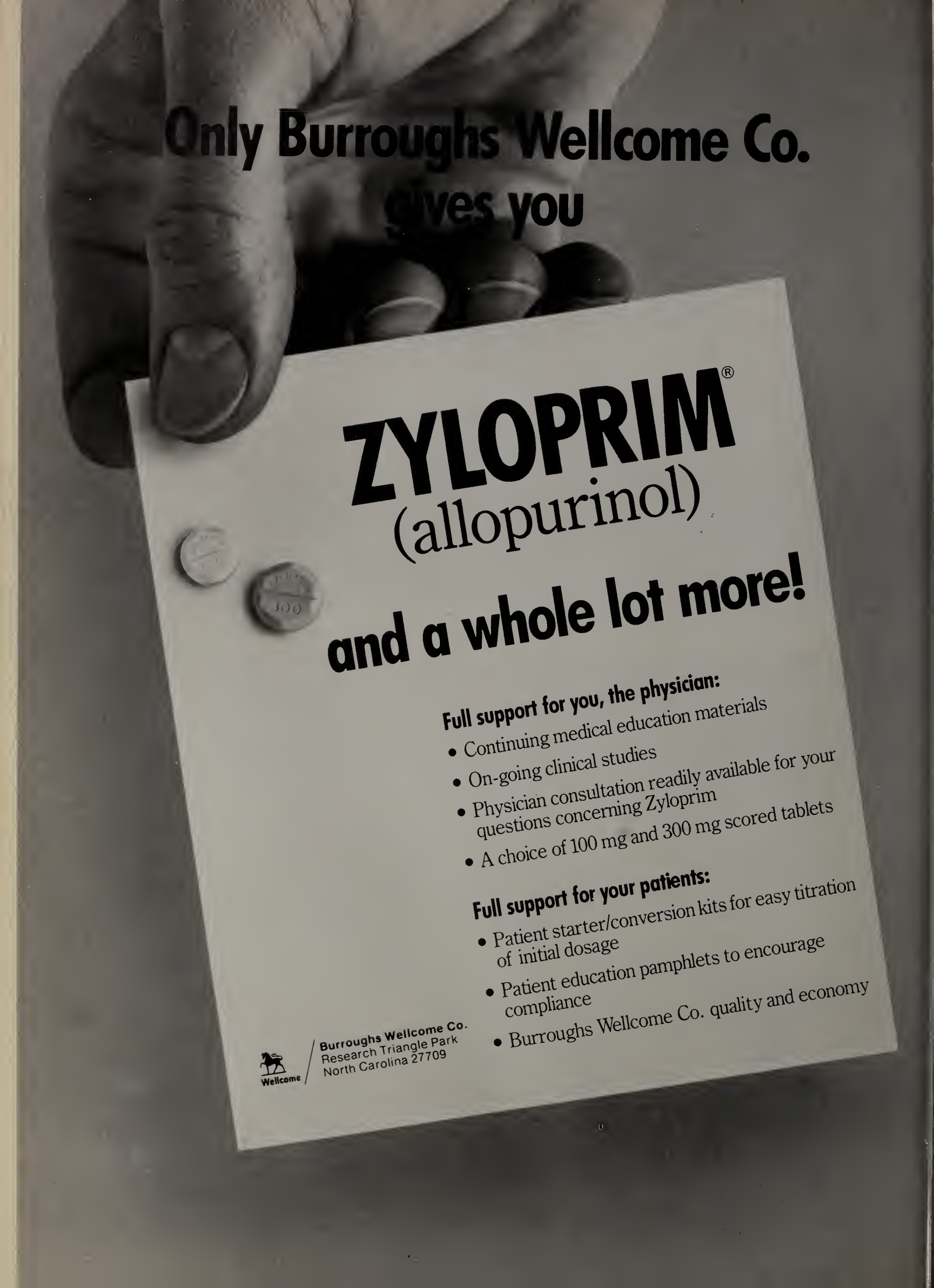
I don't know what the leadership can do to attract attention earlier. A new site for the Annual Meeting was chosen and it was one which should have been attractive both from the standpoint of travel and also family interest. There was a good balance of scientific presentations and those of public and social interest. Yet young practitioners were not in evidence and they are the very ones who will be most affected by the issues which are only now beginning to tiptoe about. I can't believe they are too busy or can't afford to attend. The same names, the same faces are predominant year after year. Few were the attendees who were not there officially.

Of course this year the general attention-getter was the alphabet soup of reimbursement and cost-containment schemes, DRG, PPO, HMO, EPO, PRO, etc., and I heard a lot of "Where'd that come from?" Well, they didn't just burst on the scene. They have been quietly circulating for several years. Only now are they accomplished fact and we must begin the accomodation process.

What are the whisper-soft issues today that will be the loud voices in a few years? I don't know for sure and what they are isn't my point. Those who heard Jules Bergman, the Abel S. Baldwin lecturer, were pricked by a few barbs the ABC News Science Editor cast at the comportment of some doctors. He is not an enemy of Medicine but he is an observor of the human scene and his criticisms were those he hears in the course of his work. They were not well received by some in attendance which makes my point. He was talking to the wrong audience. Young doctors must listen. They must participate. After all, it is their profession which they have already inherited from us.

J.K. Conn, M.D.
Tallahassee




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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.
MAY 1984 Vol. 71, No. 5

Introduction: Symposium on Bone Marrow Transplantation — 1984

In 1982 there were 15 bone marrow transplantation centers in the United States reporting on 750 transplants and one year later 37 centers reported more than 1,000. The rapid increase in using bone marrow transplantation as curative therapy for patients suffering from failure or malignancy of lymphohematopoietic system is an indication of the increasing success rate for bone marrow transplant in, as well as the application of, the technique for treating new diseases. In 1981 the University of Florida Bone Marrow Transplantation Program performed its first allogeneic bone marrow transplant and expanded its research and treatment program in the use of intensive chemotherapy.

The series of articles which follow provide an historical perspective as well as an in-depth presentation of the "state of the art" of bone marrow transplantation. In addition to presenting the curative potential of bone marrow transplants for selected diseases, we present the problems associated with transplantation, the scientific challenges they present, and some insights into the research directions being pursued to expand efficacy and safety of such endeavors. The field of bone marrow transplantation is a rapidly moving one. Basic and clinical research in immunogenetics, infectious diseases, immunology, and radiobiology is contributing vast amounts of information and a prodigious number of new journal articles. Each of the articles which follow is extensively referenced so that the reader can delve more deeply into topics of interest. It is our hope that they will help prepare clinicians to cope with the new knowledge, challenges, and opportunities stemming from bone marrow transplantation.

The authors are active members of the Bone Marrow Transplantation Program at the University of Florida and maintain an active research program in transplantation biology. They invite inquiry concerning bone marrow transplantation as well as specific clinical problems for which the procedure may present a reasonable therapeutic option.

Roy S. Weiner, M.D.
Samuel Gross, M.D.
Co-Directors
Bone Marrow Transplantation Program
University of Florida College of Medicine
Gainesville

Current limitations and future utilization

Renee V. Gardner, M.D. and Samuel Gross, M.D.

Our cumulative experiences with bone marrow transplantation (BMT) have taught us that this therapeutic modality can be widely applied. Its increasing margin of safety will soon afford many uses besides those of treatment of marrow aplasia and the leukemias. Both human and animal data have demonstrated the transferability of normal cellular characteristics from donor to host. The replacement of dysfunctional cellular types and the correction of the ensuing organic dysfunction are, of course, dependent upon the absence of toxic metabolites or products of nonhematologic cell lines which are extrinsically responsible for those defects seen.

Recently the transfer of human cyclic neutropenia from one affected sibling to another with acute leukemia was accomplished with allogeneic bone marrow grafting.[1] Generally, however, it is unusual to have human transplant donors with genetic or other hematologic disorders. The more extensive animal experience does allow the theory of characteristic transfer to be borne out. Replacement of peripheral blood enzymes, beta-glucuronidase, catalase and lipase has previously been achieved in animal models.[2] Cyclic neutropenia can be aborted or initiated in the grey collie dog by bone marrow transplantation.[3] Dogs with severe hemolytic anemia secondary to pyruvate kinase deficiency were subjected to bone marrow transplantation with resultant correction of the hematologic disorder.[4] The usual long-term sequelae of pyruvate kinase in these animals were precluded by transplantation. Surprisingly, reversal of iron overload in these animals, at times quite heavy, occurred over a variable period of time after hematopoietic reconstitution had taken place.

The spontaneous development of diabetes in the BB rat is of probable cell-mediated etiology as suggested by the prevention or amelioration of the

The Authors
RENEE V. GARDNER, M.D.
SAMUEL GROSS, M.D.
Drs. Gardner and Gross are with the Bone Marrow Transplantation Program and the Department of Pediatrics at the University of Florida College of Medicine, Gainesville.

disease with immunosuppressive therapy.[5] After inoculation of bone marrow from normal MHC-compatible donors and subsequent allografting, the susceptible rats had a markedly decreased incidence of diabetes. It is postulated that the restoration of T-cell numbers and reactivity after BMT affords some protection against insulitis and its resultant glucose intolerance.

The pluripotential nature of the stem cell compartment, restored by BMT, allows repopulation of other bone-marrow-derived cell compartments in the body. The reticuloendothelial system is essentially derived from monocytic precursors within the bone marrow. Similar derivation has been proven for the alveolar macrophage and is implied for the brain macrophage and osteoclast as well.[4]

Current applications: • Having demonstrated the efficacy of BMT in conferring normal function upon previously dysfunctional hosts, while using animal models, transplantologists made the additional step initiating treatment of various immunologic and metabolic disorders plaguing man with BMT.

Most inborn errors of metabolism do not easily lend themselves to treatment. Dietary manipulation, as seen in the treatment of phenylketonuria, is rarely efficacious for the majority of these disorders. The reordering of genetic codons or exogenous enzyme administration are alternatives which are neither practical nor practicable at present.

BMT, however, is a viable option which, with lessening complications, can be offered to an increasing number of patients with metabolic or other disorders. The enzymatic deficiencies of these diseases may be partially or totally corrected by the engrafted leukocytes of normal donors which have high activity of these defective or deficient enzymes.[7] BMT efforts here have been tentative and the results early.

A one-year-old infant with Hurler's syndrome underwent BMT.[8] After the graft was established, enzyme levels rose to heterozygous levels. Such levels were detectable at 13 months post-transplantation and the clinical manifestations of hepatosplenomegaly and corneal clouding slowly resolved. Neurologic degeneration appeared to be arrested. This latter observation must, of course, be tested by time since arrest and progression of neurodegeneration are seen intermittently in the course of this and similar disorders. Similar clinical improvement has been noted post-transplant in other mucopolysaccharidoses.[4]

A wider application of BMT has been in the treatment of immunodeficiency syndromes. BMT has been the ideal therapeutic approach to patients with severe combined immunodeficiency disorders (SCID).[9,10] These individuals suffer grave and opportunistic infections early in life because of the absence of both T and B-lymphocytic function. Early death is almost universal. Immunosuppressive pretransplant preparation is not usually necessary. With this therapeutic modality, survival and cure rate now can approach 60%. Graft-versus-host disease (GVHD), if present, is usually mild and/or short-lived.

The SCID patient presents several interesting features for study that merit discussion. Approximately 50% are adenosine deaminase (ADA) deficient.[11] Such a deficiency is ultimately responsible for impairment of DNA synthesis and methylation. Both of these cellular activities are necessary for normal cellular function. With engraftment of T-lymphocytes from normal donors, the ADA-deficient patient is able to develop normal T and B-lymphocytic function.[11] The extent of restoration of T-cell function is dependent upon the age at which treatment is started. The engrafted T cells are almost always of donor origin, whereas host B cells may persist, resulting in lymphocytic chimerism. Long-term follow-up studies indicate normal numbers/ratio and function of B and T cells by two years post-BMT.[12]

The Wiskott-Aldrich syndrome has also been completely corrected by BMT.[13] After this procedure, platelet size, number and function were normal[14] and eventual attainment of normal B and T cell activity was noted.[15,16] Additional defects of immunity which have been a target for stem cell replacement through transplantation include: primary actin defect of granulocytes preventing normal migration, chemotaxis and phagocytosis;[16] the Bare lymphocyte syndrome;[17,18] Chediak-Higashi syndrome;[19] Kostmann's syndrome,[20] and various miscellaneous disorders of granulocyte function.[21]

Osteoclasts have been differentiated from normal pluripotential stem cells after transplantation for osteopetrosis proved successful.[6,22,23] Bone remodeling and reversal of rachitic changes subsequently occurred. The immunologic dysfunction accompanying osteopetrosis, ie, impaired monocytic bactericidal capacity and decreased adherence, was resolved.

It would seem that defects of the hematopoietic stem cell would generate greater efforts at transplantation. However, the relative longevity of these patients and their comparably high functional level have considerably stymied efforts at BMT for hemoglobinopathies or disordered hematopoiesis. Thirteen patients with thalassemia major had transplants using histocompatible, MLR-nonreactive donors.[24] Results, unfortunately, were discouraging. Failure to achieve sustained engraftment was a major problem; however, lack of success may have stemmed from poor selection of patients for study. Many were older children who previously had been heavily transfused and had areas of extramedullary hemopoiesis; both factors may have led to relative resistance to the standard preparative regimens.

Thomas has suggested that the ideal candidate for BMT in thalassemia should be a child less than five years, having had minimal prior transfusion therapy, and thus little chance of significant iron overload.[25] BMT has also been used to successfully treat Fanconi's anemia.[26]

Lesser success has been met with the application of BMT to nonleukemic oncologic disease states. A syngeneic BMT was performed in a 50-year-old man with multiple myeloma but recurrent disease was detected within 18 months.[27] BMT has also been used to treat acute ("malignant") myelosclerosis, a uniformly fatal disorder characterized by pancytopenia and bone marrow fibrosis.[28,29] Unfortunately such attempts rarely have been met with success. In 1981 eight patients with disseminated non-Hodgkin's lymphoma, having failed conventional therapy, received bone marrow from syngeneic donors. Complete remission was achieved in seven with four remaining in complete unmaintained remission for 12 to 126 months.[30]

Limitations • Despite reasonable successes in the treatment of these disorders, the exploitation of BMT as a therapeutic modality has remained limited. Outcome is quite dependent upon age, as GVHD increases proportionately with increasing age. Therefore, only a limited portion of the population can be expected to gain from its application.

Until recently, graft rejection was the greatest hurdle to be surmounted. Elfenbein and others analyzed those factors which were crucial to engraftment, and consequently to survival, after allogeneic BMT.[31] Accurate HLA-matching and mixed lymphocyte (MLR)-nonreactivity must be considered essential. Adequate cell yield from the donor also increases the likelihood of sustainment of the graft. The risk of graft rejection increases with increasing numbers of transfusions prior to transplantation.

Immunosuppressive regimens, employing total body irradiation (TBI), also have an associated increased rate of engraftment. TBI may negate such factors as race. (Blacks have generally fared more poorly while undergoing BMT).[31]

Recognition of these factors has led to significant improvements in engraftment rates and survival. Yet, problems such as severe, overwhelming infection, graft vs host reaction, and interstitial pneumonitis persist. To use TBI in the preparative regimen may signify better engraftment chances but also may contribute to development of pneumonitis later in the course of recovery. Fractionation of TBI only partially moderates this risk of complications and is not a uniformly appropriate inclusion in the preparative regimen for all disease categories. One must also remember that irradiation and certain of the drugs employed[32,33] do have proven oncogenic potential. Another concern is the risk of oncogenicity which may be inherent to certain of these disorders with or without trigger-phenomenon such as irradiation. Fanconi's anemia with its increased chromosomal fragility is an example.[34]

Acute and chronic GVHD are now the major obstacles to the success of transplantation. Despite the prophylactic use of methotrexate, as many as 50% of individuals undergoing BMT will be diagnosed with the acute form of this disorder. Twelve to 20% of these affected patients will die of related complications.[35] Of those surviving for more than 18 days, 20% to 40% may be expected to develop chronic GVHD. (The clinical manifestations and implications of this set of disorders have been discussed at length elsewhere in this issue.)

Before engraftment has taken place, BMT patients display marked susceptibility to fungal and enteric pathogens as well as disseminated herpetic and adenoviral infections. Later in the postengraftment course, encapsulated pyogenic bacterial infections and zoster recrudescence are notable.[9] Yet, interstitial pneumonitis, idiopathic or viral, has been a significant cause of mortality among BMT recipients and has provoked the most frustration for the physician.[35] When an organism can be identified, cytomegalovirus (CMV) has been the responsible agent in the majority of instances.

Implications for future use • Applications of BMT can only be expanded in the future, if these difficulties cited are surmounted. Current efforts at improving survival have centered on the immunologic aspects of transplantation. Transplant biologists have, as of yet, an imperfect knowledge of the mechanisms of graft vs host reactions, immunologic hypofunction and complete identity of important HLA-compatibility loci.

Use of histoincompatible donors — parents, siblings, or unrelated individuals — has thus far been limited to patients with SCID.[36,37] Full marrow reconstitution with ensuing normal immunologic function has been reported. GVHD has usually been absent. Durable chimeric states similar to those seen in this disease entity, after compatible unfractionated sibling matches for SCID, have been established.

However, as previously stated, SCID remains a special case and alternative GVHD preventive measures must be invented for use in the majority of BMT recipients. Data accrued from animal experiments now suggest that the rate of engraftment and severity of GVHD in transplanted animals is dependent upon stem cell-lymphocyte ratios. Low stem cell-lymphocyte fractions have been associated with early and severe GVHD.[38] Conversely, complete

removal of lymphocytes from bone marrow inocula is not always beneficial as suggested by engraftment failures occurring after use of "purified" stem cells in lethally irradiated dogs.[38] Clearly, a delicate balance is necessary for successful engraftment without clinically significant alloreactivity.

GVHD is probably attributable to abnormal T and B-lymphocytic interactions. A "specific" suppressor cell capable of suppressing MLR of donor-to-host lymphocytes, as seen in stable chimeric states, is tentatively identified as being responsible for graft tolerance.[39] Lack of such specific suppressor cellular activity may allow continuing immune response against host non-HLA antigens. Efforts to counter this reactivity now center on attempts to pretreat donor bone marrow hoping to remove the responsible T-cell fractions. T-cell removal in bulk can be accomplished by soybean agglutination followed by differential sedimentation of residual unagglutinated T-cells.[36] Monoclonal antibody has also been used for this purpose.[40] Total lymphoid irradiation employed to abrogate rejection and GVHD lacks target specificity making it a more toxic and, perhaps, less desirable preventive approach.

Trials utilizing cyclosporin A have demonstrated effective immunosuppression by this agent.[41,42] Compared to methotrexate given prophylactically, its use was associated with less frequent and less severe GVHD. The survival difference was not statistically significant but these results indicate that cyclosporin A merits more attention in the future. Its major side effects are those of nephrotoxicity and less-well-documented neurotoxicity. The optimal dosage for this agent has not been determined and it is reasonable to conjecture that the observed toxicities could be dose-related.

Already, prednisolone use in acute GVHD has resulted in beneficial course modulation. Resolution of GVHD symptoms are seen in 67% of patients after institution of steroid therapy.[43]

As previously indicated, significant mortality (20% to 40%) is realized among BMT patients who develop interstitial pneumonitis.[36] Over half of those in whom a diagnosis can be established are found to have cytomegaloviral infection. Attempts at prophylaxis using interferon, adenine arabinoside, acycloguanosine have failed in the past. Recently, an investigation of the use of hyperimmune globulin (anti-CMV) was conducted.[44] Results are encouraging. Patients did not develop either CMV infection or interstitial pneumonitis during the period of prophylaxis. Those not receiving prophylaxis fared significantly worse. Upon cessation of prophylactic therapy, three of 17 patients subsequently developed interstitial pneumonias. Interestingly, results of antibody-poor globulin use were not significantly different from that seen with hyperimmune use.

A new and exciting development, with futuristic tones, is the use of fetal tissue transplantation.[10,45-47] Acting upon the postulate that less well-differentiated stem cells may be less apt to produce graft-vs-host reactivity, Touraine and other European investigators have accumulated the most extensive experience with this technique.[10] HLA-incompatibility has been the rule rather than the exception. Fetal liver cells, sometimes with the adjunctive use of fetal thymic tissue, have been obtained from eight to 14 week gestation fetuses and injected into the peritoneum of recipients. SCID patients have comprised the majority of patients treated in this manner, although some success has been recorded with Sanfilippo B disease, nucleoside phosphorylase deficiency, late-onset T-cell deficiency, Niemann-Pick disease, Hurler's syndrome, fucosidosis, and Fabry's disease.[10] Reversal of already present organic damage or dysfunction cannot always be expected, as in Fabry's disease, where glycosphingolipid deposits are not cleared after the transplantation. Yet, immunologic reconstitution in most individuals has been complete although slow. A drawback to this modality of treatment is the length of time (up to two years) necessary for attainment of intact immune function. Complete and prolonged isolation of patients so treated is required. Brent and others have recently made a fascinating proposal.[48] Thalassemia, diagnosed antenatally, using fetoscopy at 15 to 23 weeks gestation, would afford the opportunity to infuse normal allogeneic hematopoietic cells into the circulation of the affected fetus. The establishment of a hematopoietic chimeric state, without associated GVHD, would then allow alleviation or prevention of the clinical symptoms of thalassemia.

Conclusions • The consensus now stands that BMT or comparable alternatives have great promise for future curative uses. Investigators recently attempted transplantation of two individuals with AIDS.[49] Their efforts at restoration of immunologic competence were unsuccessful, perhaps because of the presence of reactivated virus or persistence of the causal agent. Obviously not enough information is available at this time about the etiology of this disorder. Yet, AIDS and other disorders such as alpha-1-antitryspin deficiency, Krabbe's disease, sickle cell anemia, and hereditary spherocytosis have been posed as entities amenable to correction by BMT. One must then ask questions of cost-benefit and cost-effectiveness. Ethical considerations also should never be divorced from the decision-making process as to who should have transplantation. Is it in the patient's best interest to subject him/her to a procedure with definite and considerable complications when alternate,

more conservative therapeutic measures, eg, blood transfusion in a hemoglobinopathies, may allow comfortable lifestyle or higher life-quality and achievement of near-normal life span? This question cannot now be answered but as ways are gradually and continually discovered to modulate the post-transplant course of BMT, it may become a universal treatment.

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Immunosuppression, graft-versus-host disease, and infection after bone marrow transplantation

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The intent of allogeneic bone marrow transplantation (BMT) is to replace the recipient's marrow with that of a donor. This implies the complete ablation of the recipient's immune system with subsequent reconstitution by the donor's immune system. The process of immune reconstitution may be modulated to varying degrees by graft-versus-host disease (GVHD). The resulting prolonged period of immunosuppression may have serious consequences which may be summarized in a single word — infection. Unfortunately, the infections that occur after BMT are responsible for serious morbidity and high mortality rates.

For years marrow transplanters have been aware of a number of problems that have limited the applicability and overall success rate of BMT in terms of patient survival and cure. Problem areas are:

Understanding the pathophysiologic basis of malignant and nonmalignant diseases for which BMT may be viewed as a curative procedure.

Identifying suitable donors for BMT.

Coping with the dose-limiting nonmarrow organ toxicities of immunosuppressive and cytoreductive preparative regimens used for BMT.

Preventing bone marrow graft rejection by appropriate immunosuppression.

Preventing and treating infectious disease consequent to immunosuppression and GVHD during and after the period of aplasia.

Eradicating and preventing recurrence of the disease process for which BMT was performed.

Currently when the number of disease processes for which BMT may be curative is increasing, when the donor pool is being expanded to include individuals not genotypically identical to the recipient for antigens of the major histocompatibility complex

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(MHC), when there is increased understanding of the dose-limiting toxicities of standard regimens, when marrow graft rejection has become an unusual event, and when prevention and treatment of acute and chronic GVHD may be more successful, it is apparent that a major threat to survival of BMT recipients is susceptibility to infections. About one half of allogeneic BMT recipients die from documented infections. For many malignant diseases, infection is a more frequent cause of death than recurrence of the malignancy.[1, 2] It is infrequent for BMT patients to die of nonmarrow organ failure, graft rejection, or acute or chronic GVHD without infection.

The following questions are addressed in this article primarily for recipients of fresh allogeneic, genotypically MHC-identical, sibling marrow grafts: What induces and sustains the prolonged immunodeficiency? What are the infectious consequences of the immunodeficiency? And how may they be managed or prevented? Some of the observations and comments made are also valid for recipients of fresh marrow from syngeneic (identical twin) siblings and for recipients of cryopreserved autologous marrow. Syngeneic and autologous recipients are immunodeficient and therefore susceptible to infectious complications after BMT but, seemingly, for a shorter time and to a lesser extent than recipients of fresh allogeneic, genotypically MHC-identical, sibling marrow grafts. The observations and comments are anticipated to apply also to recipients of fresh allogeneic, but genotypically MHC-nonidentical marrow (whether or not T-cell depleted) and to recipients of cryopreserved marrow purged of contaminating clonogenic tumor cells.

Causes of immunodeficiency • The immunodeficiency which exists after allogeneic BMT has a multifactorial basis. Some factors that contribute to the initiation and prolongation of the immunodeficiency state are: the primary disease process for which BMT is attempted, the therapy for the primary disease prior to preparation for BMT, the immunosuppressive and cytoreductive drugs and radiation given immediately prior to marrow infusion, the manipulations of the marrow inoculum in vitro to remove unwanted contaminating cellular elements or serum factors, the immunosuppressive therapy given after marrow infusion to prevent acute GVHD, the development of acute or chronic GVHD, the immunosuppressive therapy given to treat GVHD, and nutritional depletion which may occur in the setting of BMT. This list may well be incomplete; nevertheless, it is apparent that in any BMT recipient more than one contributing factor is likely to be operative. A brief discussion of each factor follows.

Primary disease • Obviously, children with congenital immunodeficiency syndromes enter the peritransplant period immunocompromised. As a consequence they may harbor latent or active infections that may be activated or exacerbated by the BMT procedure. What is perhaps less obvious is the immunosuppression commonly associated with the malignant diseases for which BMT is indicated. The immunosuppression seen in patients with malignant disease is, in large part, related to their therapy as will be discussed.[3] However, an accumulating body of evidence suggests an association between immunodeficiency and active malignancy by a variety of mechanisms.[4] Classic examples of this are the defective cell-mediated immunity seen in Hodgkin's disease patients prior to the use of any chemotherapy or radiotherapy[5] and the defective humoral immunity seen in multiple myeloma.[6] Furthermore, patients with hematopoietic disorders such as severe aplastic anemia and inborn errors of metabolism such as Gaucher's disease may have compromised host defense mechanisms because of neutropenia but may otherwise have essentially intact immune function.[7]

Therapy for primary disease • Most patients receiving allogeneic BMT for malignant disease are being treated for acute leukemias. For patients with acute nonlymphocytic and acute lymphocytic leukemias, current cytoreductive therapy used to induce and consolidate remissions is immunosuppressive. Early in remission, when no leukemic cells are detectable in the blood or marrow, rather profound defects in immune function may be identified when normal (ie, nonmalignant) mononuclear cells are studied in vitro.[8] This immunodeficiency is noted at precisely the time these patients are considered optimum candidates for BMT. Patients with Hodgkin's and non-Hodgkin's lymphomas (diseases for which BMT is being considered with increasing frequency) have also been shown to be immunodepressed after receiving cytotoxic therapy.[8] Humoral immunity may be impaired in Hodgkin's disease patients who have received chemotherapy and or radiotherapy.[9] Staging splenectomy may also predispose to infection.[10]

Most patients receiving allogeneic BMT for nonmalignant disease have severe aplastic anemia. It has been shown that pretransplant therapy with conventional doses of corticosteroids induces a mild humoral and cellular immunodeficiency which rarely predisposes the patient to opportunistic infections.[7] However, if allogeneic BMT is relegated to second-line therapy and employed only after failure of immunosuppressive therapy with antithymocyte globulin or high-dose corticosteroids,[11] patients with severe aplastic anemia may enter the transplant period more severely immunocompromised than when allogeneic BMT is used as first-line therapy.

Preparative regimens • Probably the most significant factor in the induction of the immunodeficient state is the regimen used for immunosuppression and cytoreduction to prepare the recipient for BMT. Whole body irradiation (up to 14 Gy) and high dose cyclophosphamide (up to 200 mg/kg) have been given to most BMT recipients. Other cytotoxic agents may be added to regimens containing cyclophosphamide and irradiation.

In any event immunosuppressive therapy is given prior to BMT in an attempt to prevent marrow graft rejection. This intense therapy produces profound marrow aplasia and peripheral blood cytopenias. The period of recovery from aplasia is variable but is on the order of weeks following BMT. In the absence of graft rejection, recovery, including lymphoid recovery, is mediated by donor cells from the marrow graft because the intensity of the lymphomyeloablative preparative therapy and the eradication of residual recipient lymphohematopoietic cells by GVH reaction[12] make reconstitution by endogenous cells highly improbable.

Marrow inoculum manipulations • At present many investigators are experimenting with a variety of techniques to render allogeneic marrow inocula free of contaminating mature, peripheral T-cells in order to reduce the probability of acute GVHD after allogeneic BMT or to render autologous marrow inocula free of clonogenic tumor cells. Successful engraftment and return of immune function have been reported after allogeneic marrow was treated in vitro with heterologous anti-T-cell antisera and complement, and after autologous marrow was treated in vitro with monoclonal anti-T-cell antibodies and complement (to eliminate a T-cell neoplasm).[13, 14] It is a theoretical possibility that committed immune progenitor cells and mature immune cells may be sufficiently depleted by marrow manipulation procedures to contribute to or prolong the immunodeficiency after BMT.

Postgrafting immunosuppression to prevent GVHD • Canine and murine allogeneic chimeras have demonstrated that prophylaxis against acute GVHD with methotrexate or cyclophosphamide respectively significantly reduces the mortality of acute GVHD.[15, 16] Based on these studies, methotrexate or cyclophosphamide is given for several months to the vast majority of patients who receive allogeneic marrow grafts. The effect of these two agents on the lymphoid recovery potential of the marrow graft is unknown as very few patients have received allogeneic marrow without postgrafting immunosuppression.[17] In fact, the trend has been to add more immunosuppressive agents such as corticosteroids or antithymocyte globulin to methotrexate or to substitute other immunosuppressive agents such as cyclosporin A for methotrexate in an effort to prevent acute GVHD.[18, 19] However, postgrafting immunosuppression does not bear sole responsibility for the immunodeficiency after allogeneic BMT since syngeneic and autologous BMT patients do not receive postgrafting pharmacologic immunosuppression and are nevertheless quite immunodeficient early after BMT.[20, 21]

Acute and chronic GVHD • There is now good evidence that the occurrence of acute GVHD delays recovery of immune function after allogeneic BMT.[22, 23] Antibody production and cutaneous delayed hypersensitivity responses are both impaired. Apparently by independent mechanisms, chronic GVHD also delays recovery of immune function after allogeneic BMT, impairing antibody production as well as cutaneous delayed hypersensitivity. The mechanisms underlying these events will be discussed later in this article.

Cyclosporin A has been shown to be effective, compared with methotrexate, as prophylaxis against acute GVHD.[24] Preliminary studies show, unfortunately, no acceleration of recovery of immunoglobulin levels in cyclosporin A-treated patients as compared with methotrexate-treated patients.[25] Further studies are needed to clarify this area.

Therapy for established acute and chronic GVHD • Because virtually all patients with clinically significant acute or chronic GVHD receive immunosuppressive therapy in an attempt to abrogate the graft's immune destruction of recipient tissue, it is impossible to separate the immunosuppressive effects of GVHD from those of its therapy. High doses of corticosteroids or antithymocyte globulin are given for several weeks to treat acute GVHD.[26, 27] Therapy for chronic GVHD involves corticosteroids and azathioprine or cyclophosphamide for many months.[28] These immunosuppressive agents may prolong the immunodeficiency seen in patients with acute and chronic GVHD. In one multifactorial analysis, the use of antithymocyte globulin after BMT was identified as an independent variable contributing to delayed immune reconstitution above and beyond the effect of the acute GVHD for which it was given.[23]

Nutritional status • There is an established relationship between malnutrition, especially protein malnutrition, and immunodeficiency.[29] In the early years of BMT prior to the routine use of total parenteral nutrition (TPN), patients were in a state of profound negative nitrogen balance because of decreased intake due to anorexia, stomatitis, and gastroenteritis complicating preparative therapy and mucosal infections and because of increased catabolism due to fever

and systemic infections. Moreover, even the use of TPN may be insufficient to fully reverse the catabolic state seen in the face of severe infections.

Mechanisms of post-BMT immunodeficiency • Recovery of hematopoietic function is reflected by the appearance of donor neutrophils, platelets, and erythrocytes in the recipient's circulation. It would be ideal if the recovery of immune function after BMT was likewise reflected by the appearance of donor lymphocytes in the recipient's circulation. This, however, is not the case. The cellular basis for the post-BMT immunodeficiency is not well understood; neither, moreover, are the mechanisms for recovery from the immunodeficiency.

The immunodeficiency state after BMT is multifactorial in origin and probably involves, to one extent or another, at least several of the following postulated mechanisms:

The number of immunocytes may be insufficient for normal function—a quantitative or proliferative defect.

The immunocytes present may be poorly functional or incapable of normal immune function—a qualitative or functional defect.

The immunocytes present may be functionally inhibited by cellular elements or serum factors—a suppression immunoregulatory defect.

There may be an imbalance in the numbers or functions of immunocytes and accessory cells necessary for normal immune function—a cooperation immunoregulatory defect.

The immunocytes present may not function normally due to immaturity—a cellular differentiation defect.

Recovery from post-BMT immunodeficiency • The reestablishment of normal immune function takes many months to years and follows a predictable pattern for syngeneic and autologous as well as for allogeneic BMT recipients. Similar mechanisms of recovery appear operative in all three patient groups after lymphohematopoietic ablation and BMT, although the time course differs. Patients reconstituted with allogeneic cells (from donors who are histoincompatible only for minor transplantation antigens) recover more slowly than those reconstituted with isogeneic cells (completely histocompatible fresh syngeneic or cryopreserved autologous marrow) suggesting a role for minor transplantation antigens in modulating the pace of immune recovery.[20]

An attractive hypothesis is that redevelopment of normal immune function after BMT requires proliferation of immune cells, differentation of immune cells, and establishment of a critical balance of cellular elements of immunoregulatory networks. Restoration of normal immune function is a complex problem when intercellular balance must be achieved for proper function. The pace of recovery is probably genetically determined. An allogeneic environment imposes a delay upon the kinetics of recovery. Perhaps additional time is required for "education" about new self (recipient) antigens among which new (donor) immune cells are maturing. Active GVHD, whether acute or chronic, further delays the kinetics of recovery.

Consequences of post-BMT immunodeficiency • As stated, the primary consequence of immunodeficiency is infection. Fever is virtually a universal occurrence in the setting of BMT and about 95% of allogeneic marrow recipients will have a documented infection in the early post-BMT period.[30] There is a mean incidence of about one infection per 40 days at risk. Sepsis occurs in about 50% of patients and pneumonitis in about 40%. The incidence of certain types of infection, such as pneumonia, appears to be related to the incidence of acute and chronic GVHD, the use of high dose corticosteroids, as well as to the preparative transplant regimen, especially whole body radiation. Furthermore, cytomegalovirus (CMV) infection is in and of itself immunosuppressive and may predispose patients to fungal infections.[31]

The causative organisms encountered are legion including common gram negative bacilli and gram positive cocci, fungi, viruses, and protozoa. In the setting of profound granulocytopenia and immunocompromise, the classic signs and symptoms of infection may be muted.[32] Evaluation of chest roentgenograms may be exceedingly difficult because the characteristic appearance of pneumonias due to various organisms is lost.[33] Several unusual syndromes of overwhelming pneumococcal sepsis[34] and of gastroenteritis[35] have also recently been reported. Specific organisms may vary somewhat from center to center depending upon the local situation. For instance, the frequency of documented aspergillosis may vary from 10% to 20%.[30, 36] Units with construction going on in the vicinity are particularly prone since Aspergillus is a soil organism which becomes airborne during construction work.

For reasons which will be discussed in detail, as the newly implanted immune system matures after BMT, the pattern as well as the frequency of infection changes. This leads to difference in peak incidences of specific infecting organisms with time.[33, 37] The median time of onset of fungal, bacterial, viral, and protozoan infections are days +8, +18, +79, and +96 respectively. Further, among viral infections there is a triphasic pattern with peak incidences of *Herpes simplex*, cytomegalovirus, and varicella-zoster occurring at about days +5, +55, and +130 respectively.

It may take two years or more to fully reconstitute the immune system after allogeneic BMT. For this reason, the marrow recipient is at continued risk to a variety of viral infections, eg, varicella-zoster, mumps, rubella, and exotic bacterial, fungal, and protozoan infections, eg, *Listeria monocytogenes*, *Nocardia* sp, *Pneumocystis carinii*, for a considerable period of time (see below). Nevertheless, the overall risk of serious or fatal infections decreases well before full immune reconstitution. There is a dramatic decrease in incidence of infection by day 100-120 posttransplant.[33, 38] Indeed, in patients who survive at least six months after BMT, about one third will have no significant infections at all thereafter.[39] This is why most major bone marrow transplantation centers, including the University of Florida, strongly advise allogeneic marrow recipients to remain in the vicinity of the transplant center for the first 100 days after BMT and then recommend a gradual return to normal activities at home, with return to full normal activities after about six months.

Even in the two thirds of six-month survivors who do experience one or more late infections, the partially reconstituted immune system affords adequate protection in most cases. As opposed to a mortality rate from infection of 60-70% in the early post BMT period,[33] less than 10% of six-month survivors ultimately succumb to infection.[39] Virtually all late infectious deaths occur in patients who have chronic GVHD.[39]

In terms of the pattern of immune reconstitution, susceptibility to infections after BMT can be considered in four periods of unequal length: (1) the period of aplasia, (2) the early period of immune recovery, (3) the late period of immune recovery, and (4) the period of restored immunocompetence.

Period of aplasia • Preparative immunosuppressive and cytoreductive therapy administered prior to BMT is lymphomyeloablative causing profound lymphopenia, neutropenia, and monocytopenia. Repopulation takes approximately three to four weeks. Aside from profound cytopenias, preparative therapy also damages cutaneous and mucosal barriers to invading organisms. Damage to these important host defenses is also repaired during the first month after BMT. Lastly, microbial agents such as viruses which lay dormant in the recipient may be activated by the preparative therapy given for BMT and by the GVH reactions that follow.

Susceptibility to infectious diseases is highest during the period of aplasia. The major causes of infections during the period of aplasia are: gram-negative enteric organisms, gram-positive cocci, gram-positive organisms colonizing the skin, enteric fungi, fungi acquired by inhalation of spores, and herpes simplex viruses. Also during the period of aplasia, CMV is likely to be acquired although its clinical manifestations may not be expressed until the subsequent phase. The mode of acquisition appears to be by nucleated cells transfused with blood products.[40, 41]

Aside from acquisition of pathogens or invasion of colonizing microorganisms, BMT patients may develop infectious diseases by activation of endogenous dormant agents. The principal example of this is *Herpes simplex* infections.[42] BMT recipients with previous histories of herpetic infections or with high antibody titers to *H. simplex* viruses have an extraordinarily high incidence of developing severe herpetic stomatitis after BMT. Those with no prior history or no detectable antibody have a low incidence of herpetic stomatitis.

Early recovery • The early period of recovery of the immune system extends from the end of the first month after BMT until the end of the fourth or fifth month where it merges into the next phase — the late period of immune recovery. In these patients, mucosal barriers have been repaired, neutrophil function is sufficient but immune function remains ineffective.

Patients who develop moderate to severe acute GVHD, which occurs during the period of early recovery, are ordinarily treated with high doses of corticosteroids or antithymocyte globulin for a few weeks. As discussed previously, their immunodeficiency is at least prolonged, if not worsened, by acute GVHD and by the immunosuppressive therapy used to treat the acute GVHD. This is not to say that patients who do not develop acute GVHD are not profoundly immunosuppressed. They are, but for a briefer period than those who develop acute GVHD.

The most frequent infections during this period are due to: gram-negative enteric organisms, gram-positive infections arising from skin colonizing organisms, enteric fungi, and interstitial pneumonitis. In many regards the pattern of infectious disease is much like that during aplasia with the exception of interstitial pneumonitis.

The reason for the similar patterns is that during acute GVHD cutaneous and gastrointestinal barriers to invasion of microorganisms may again be broken down. Mucosal manifestations of severe acute GVHD include cutaneous desquamation and severe diarrhea associated with a disrupted intestinal mucosal barrier. From animal model studies in which germ-free mice are given allogeneic, MHC-histoincompatible marrow grafts, it appears that the enteric mucosal lesions typical of acute GVHD are the result of synergism between engrafted lymphoid cells and colonizing enteric bacteria.[43] Germ-free mice do not develop enteric mucosal lesions unless their guts are colonized by normal enteric flora. In support of this observation, a reduction of the incidence of acute GVHD has recently been demonstrated for patients

with severe aplastic anemia whose guts have been decontaminated by nonabsorbable antibiotics and sterile diets and who have been cared for in laminar air flow rooms.[44] Also, since virtually all BMT patients have had antibiotics during aplasia, it is not at all surprising that many of the invading bacteria during this period are antibiotic-resistant.

The problem of interstitial pneumonitis plagues the practice of BMT as much, if not more, than the problem of recurrent malignancy because once it develops therapeutic interventions are usually futile.[45, 46] In spite of this pessimistic tone, much has been learned about interstitial pneumonitis over the last decade and with certain anticipated advances in the development of antiviral agents and more innovative use of radiation therapy the situation may improve in the future.

Interstitial pneumonitis ordinarily occurs at a median of day +50 to +60. It occurs in about 40% of BMT patients. It typically presents a dry cough, dyspnea, and fever with tachypnea, dry rales, restricted ventilatory capacity due to decreased pulmonary compliance, hypoxia, and bilateral diffuse interstitial or reticulonodular infiltrates. It is fatal in approximately two thirds or more of patients due to the hypoxia which develops from nearly complete alveolar capillary blockage. Retrospective and prospective studies show that the principal etiologic agent is CMV, accounting for about 50% to 65% of cases.[30] In approximately 20% to 30% of cases a pathogen is never identified despite intensive search including sputum analysis (low yield) and lung biopsies (higher yield) for bacterial, fungal, mycobacterial, and viral cultures as well as extensive histopathologic studies. The remaining 10% to 20% of cases are attributable to protozoa *(Pneumocystis carinii, Toxoplasma gondii)*, fungi (Candida sp, Aspergillus sp), bacteria (gram-negative rods), other viruses (adenovirus, *Herpes simplex)*, or *Chlamydia trachomatis.*[45, 46]

Three important risk factors promote the development of interstitial pneumonitis in the setting of post-BMT immunodeficiency: acute GVHD, radiation therapy, and, for CMV interstitial pneumonitis, possibly granulocyte transfusions.[47] Two series have now demonstrated an increased incidence of interstitial pneumonitis associated with acute GVHD.[46, 48] Animal studies have shown that GVH reactions activate dormant endogenous viruses.[49] Human pathology studies have demonstrated a lymphocytic bronchitis in patients with acute GVHD.[50] Thus, by activating viruses and, perhaps, by damaging the pulmonary parenchyma as well as the airways, acute GVHD may promote interstitial pneumonitis. Finally, there is a recent report that the use of methotrexate as prophylaxis against acute GVHD and the use of a female marrow donor for a male recipient may increase the risk of interstitial pneumonitis.[37]

Other infections, predominantly viral and protozoal, may develop in patients irrespective of the occurrence of acute GVHD. Hepatitis is a common clinical syndrome after BMT and may be hepatitis A, hepatitis B, or non-A, non-B hepatitis. CMV is one major cause of non-A, non-B hepatitis. Another major cause is reported to be BK virus (a papovavirus) which has frequently been found in patients with acute nonlymphocytic leukemia.[51] A high incidence of Epstein-Barr virus infection is also suspected because of the large number of BMT recipients whose antibody titers to Epstein-Barr virus rise after BMT.[45] CMV may also affect the gastrointestinal tract. Many other viruses, such as rotavirus, adenovirus, and Coxsackie virus, may affect the gastrointestinal tract in apparently epidemic fashion.[35] CMV has been suspected to be the etiologic agent in a number of cases of transient hemolytic anemia, thrombocytopenia, and pancytopenia after BMT. Lastly, cases of toxoplasmosis involving the central nervous system after BMT are well documented and most probably represent activation of endogenous dormant protozoa.[52, 53]

Late recovery • The late period of recovery of the immune system begins during the fifth or sixth month after BMT and extends into the second year when it gradually merges into the next phase, restored immunocompetence. During this risk period, about a third of BMT patients escape infections.

However patients who develop chronic GVHD, which often occurs during this time period, have particular difficulty in producing antibodies as previously discussed. This difficulty is associated clinically with a susceptibility to infections caused by encapsulated bacteria.[28, 45, 50, 54] The infections may begin innocuously but can fulminate rather quickly and may be fatal. Among the classes of organisms responsible for life-threatening infections in patients with chronic GVHD are gram-positive cocci *(Streptococcus pneumonia* and *Staphylococcus aureus)*, gram-negative cocci, coccobacilli, and gram negative rods *(Neisseria meningitides, Hemophilus influenzae*, and *Klebsiella pneumonia)*. As mentioned earlier, overwhelming pneumococcal sepsis syndromes may occur. Fungal infections, particularly mucocutaneous candidiasis, also seem to be more common in patients with chronic GVHD.[45]

The most common viral infection during late recovery after BMT is due to varicella-zoster virus.[39, 45] It usually occurs more than three months after BMT. Peak incidence seems to be in the fifth and sixth months but may occur years after. Its incidence (40% to 50%) parallels that seen in patients with Hodgkin's disease treated with chemotherapy, radiotherapy, or both.[55] It presents equally often as dermatomal dis-

ease or as disseminated disease. Although rarely fatal, the acute illness can produce residual muscular atrophy and neuralgia or become superinfected. Both localized and systemic infections may be serious. Ocular (ophthalmic branch of the trigeminal nerve) zoster can threaten vision by producing ulcerating and penetrating keratitis. Varicella pneumonitis and meningoencephalitis are life threatening. The occurrence of varicella-zoster virus infections seems to be independent of chronic GVHD although some investigators feel chronic GVHD may start after varicella-zoster virus infection.[56] In all likelihood, varicella-zoster infection is a reactivation disease since it appears to be unrelated to viral exposure.

Among bacterial infections that may develop are those caused by *Listeria monocytogenes* and Nocardia sp., which produce meningitis and pleuropulmonary infections respectively.

Restored immunocompetence • Upon restoration of immunocompetence, BMT patients are no longer susceptible to opportunistic infections but may still develop other infections. Many infections during this phase are typical childhood illnesses such as mumps and rubella.[45] Development probably reflects lack of transfer of immunologic memory from marrow donor to BMT recipient. BMT patients ordinarily develop these infections after exposure and generally handle them without problem. In some ways, although immunologically competent, BMT patients are immunologically naive for years.

Prevention of infections • Prevention of infectious diseases for BMT patients follows the same general rules as prevention of infectious diseases for any population of patients at high risk, but with a few twists. Risk reduction is attempted by several mechanisms: (1) reduction of exposure to potential pathogens, (2) boost of host defenses by immunization, (3) chemoprophylaxis, and (4) attempted reversal of immunosuppressive processes such as GVHD. This section illustrates how infections can practically or theoretically be prevented by these approaches. Once the pathophysiology of infections after BMT is more fully understood, it will be easy to conceive of specific methods of infection prevention beyond those described here.

Elimination of pathogens • Since no infection occurs without a pathogen, it is logical to speculate that eliminating pathogens from the environment of a susceptible individual and preventing activation of dormant endogenous agents would reduce the incidence of infections. Specifically, reverse isolation and visitor restrictions are enforced during the period of aplasia to prevent acquisition of pathogens from the exogenous flora. One BMT center has shown that intestinal decontamination with nonabsorbable antibiotics, decontamination of the skin with disinfectants, sterile laminar air flow rooms, sterile diets, and aseptic nursing techniques reduced the incidence of bacterial sepsis.[57] Moreover, as mentioned, laminar air flow rooms may reduce the incidence of GVHD, thus limiting another risk factor for infection.

It is difficult to conceive how activation of endogenous dormant virus may be avoided. Avoidance of or fractionation of irradiation in the preparative regimen and prevention of acute GVHD may reduce the incidence of CMV interstitial pneumonitis.[58] Doing so, however, must be weighed against the potential reduction of antileukemic effect produced by eliminating or fractionating total body irradiation and preventing acute GVHD.[59]

Boosting host defenses • Improving the ability of a BMT patient to cope with an invading microorganism is another logical way to prevent infections. This may, theoretically, be accomplished by immunizations, both active and passive. Active immunization against CMV has been contemplated but appears to offer little hope for success. Immunization with the currently available vaccine seems to provide little protection in high risk, non-BMT patients and BMT patients are not likely to make antibodies to CMV because of their immunodeficiency.[60] On the other hand, passive immunization of BMT has been shown by two groups to reduce the incidence of CMV infections after BMT.[61, 62] It is our current policy at the University of Florida to administer weekly gamma globulin with high anti-CMV titers to all bone marrow recipients whose donors were anti-CMV positive or who themselves were anti-CMV positive. Treatment is begun whenever the patient's titers fall below 1:128 and is continued until day +100.

Chemoprophylaxis appears to be a successful method to handle certain specific pathogens. Acyclovir given prophylactically to BMT recipients delays the onset of herpes simplex virus infections. The herpetic lesions that do develop after acyclovir treatment produce much less morbidity than those that occur when no acyclovir has been administered.[42] Similarly, cotrimoxazole appears to reduce the incidence of encapsulated bacterial infections in patients with chronic GVHD.[54, 63, 64] Lastly, interferon, an antiviral biological agent, is theoretically useful in preventing CMV infections although, in one series, it was ineffective as treatment for established CMV pneumonia.[65, 66] We do not, therefore, currently use interferon in view of its attendant toxicities which include myelosuppression.

Reversal of processes underlying enhanced susceptibility • Much attention has been paid to preventing acute GVHD and two avenues are under study. One

method is treating the recipient after BMT prophylactically with more effective immunosuppression than is provided by methotrexate alone, ie, antithymocyte globulin, prednisone, and methotrexate; or with more selective anti-GVHD immunosuppression than is provided by methotrexate, ie, cyclosporin A. The other method is treating the donor marrow ex vivo to deplete the marrow of mature T-cells. These techniques have involved monoclonal anti-T-cell antibodies with complement (J. Ritz, personal communication) and physican depletion of T-cells by eliminating E-rosette-forming cells with or without adherence to the plant lectin soybean agglutinin.[67, 68] None of the studies with T-cell depleted marrow have sufficient numbers of patients to make a comment about the incidence of infectious complications, in particular, interstitial pneumonitis. Both of the studies of improved prophylactic therapy for acute GVHD have yet to show a reduction of opportunistic complications, in particular, interstitial pneumonitis.[18, 24]

The only published trial attempting to accelerate immune recovery involved intramuscular implantation of precultured thymus gland fragments eight days after BMT.[69] This failed to reduce the incidence of interstitial pneumonitis or varicella-zoster virus infections in the 17 patients studies. However, these results are difficult to interpret because no viable thymic epithelium could be identified when the implantation sites were subsequently biopsied.

It appears warranted to begin clinical trials with selected biological response modifiers in an attempt to accelerate restoration of immunocompetence. Possible candidates for such trials are thymosin fraction V, thymosin ∝-1 (one purified polypeptide from the thymosin fraction V mixture), thymopoietin pentapeptide, *facteur thymique serique*, and interleukin-2.[70-74] The role of thymic epithelial grafts may deserve reexamination.

Management of infections • This section is brief because its primary purpose is to provide guidelines for management of nonviral infections and secondarily to discuss recent advances in antiviral therapy.

The basic principles by which infections should be diagnosed and treated are the same for BMT patients as for other high-risk patients. Intensive evaluation including appropriate biopsies should be performed to identify specific pathogens responsible for infectious processes. In the case of a febrile granulocytopenic BMT patient, the current policy at the University of Florida is to initiate empiric broad spectrum antibiotics (a first generation cephalosporin, an aminoglycoside, and carbenicillin) immediately after a physical examination and cultures of blood and all symptomatic sites. If a specific cause for the fever has not been identified and the patient remains febrile and granulocytopenic on the seventh day, then amphotericin B is empirically added to the regimen. This is because of the high risk of fungal infections mentioned earlier (median occurrence of day +8) and because of the difficulty in documenting invasive fungal disease premortem.[32, 75] In nongranulocytopenic patients, the source of infection is often more readily apparent (eg, pneumonitis) and biopsies are taken very early in the management.

Antiviral therapy for *Herpes simplex* virus and varicella-zoster virus is now available. Acyclovir reduces viral shedding, reduces complications, and speeds healing of herpetic lesions.[76] Interferon is under evaluation for treatment of varicella-zoster virus infections and appears promising.[77] Adenosine arabinoside is also effective against *H. simplex* and varicella-zoster viruses but appears more myelotoxic than acyclovir or interferon.[78]

Antiviral therapy for CMV is sorely needed. Few antivirals with activity against CMV are even available for clinical trials at this point. One compound that will be available soon is trifluorothymidine which inhibits human CMV proliferation in vitro at a concentration one thirtieth of that which inhibits human myeloid progenitor cell proliferation.[79] Two other compounds worth mentioning, because of promising in vitro activity against CMV, are phosphonoformic acid and 2′-fluoro-5-iodoarabinosyl cytosine.[80, 81] These may also come to clinical trial. Unfortunately no compound has yet proven effective in therapy for human CMV infection.

Summary

The major consequence of immunosuppression and GVHD is infection. BMT patients seldom die of organ failure from preparative therapy, graft rejection, or GVHD. Understanding the pathophysiology of the post-BMT immunodeficiency and the pathophysiology of opportunistic infections provides clues for diagnosis, prevention, and management of infections after BMT. Understanding the mechanisms of recovery of the cellular elements of the immune system after BMT may also ultimately provide valuable insights in designing new clinical trials to accelerate restoration of immunocompetence after BMT. As post-BMT immunosuppression is modified and its consequences are more successfully managed, BMT will, hopefully, become safer and, therefore, appropriate for study in a broader spectrum of human disease.

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Therapeutic applications of allogeneic BMT: Aplastic anemia and the leukemias

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ABSTRACT: Bone marrow transplantation (BMT) offers potentially curative therapy for a variety of hematologic, immunologic, and neoplastic disorders. The application of BMT to human disease evolved from basic research efforts, especially in the area of radiation effects. BMT is the treatment of choice for severe aplastic anemia. Patients with acute myelogenous leukemia and with acute lymphocytic leukemia have been cured after BMT. In addition, BMT may offer the first hope for cure for young patients with chronic myelogenous leukemia. The biologic barriers of genetic restrictions, severe immunosuppression, and graft-versus-host disease limit BMT to specialized centers with active research programs.

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Bone marrow transplantation offers the potential for cure for a variety of hematologic, immunologic and neoplastic disorders. This article reviews the development of the technique and its subsequent application to the treatment of aplastic anemia and the leukemias. We have emphasized the role of basic research and of biologic barriers in marrow transplantation so that the practitioner can follow future developments in this rapidly expanding field.

Historical Background • Over 5,000 bone marrow transplants (BMT) have been performed in an attempt to cure lethal diseases of marrow failure or of hematopoietic malignancy. Ninety years have elapsed since the first attempted "transplant" in which glycerol extracts of bone marrow were given orally to patients with marrow failure or with leukemia.[1] Intramedullary and even intravenous infusions of marrow were attempted without success in the late 1930s and early 1940s.[2,3] The modern era of BMT really began in the 1940s as basic research in the areas of radiobiology, genetics, immunology, pharmacology and microbiology evolved.

During government-sponsored research of the potential medical consequences of radiation exposure from a nuclear catastrophe, Leon Jacobson observed that mice given radioactive strontium (89-90Sr) developed marrow aplasia but not anemia. Since 89-90Sr was concentrated in bone, the spleen was spared and assumed hematopoietic function. Jacobson transplanted hematopoietic spleen tissue into splenectomized mice treated with 89-90Sr to prove that hematopoietic function is transplantable.[4-6] Jacobson's interpretation was that the spleen somehow detoxified the radiation effects on marrow tissue or perhaps elaborated a humoral substance

which accelerated endogenous recovery of marrow function. The concept of cellular seeding was considered a remote possibility.[7]

Egon Lorenz was studying dose responses and the effects of acute and chronic radiation exposure upon inbred strains of mice. In 1951 he and his colleagues reported the first successful experiments using normal isologous bone marrow cells to repopulate lethally irradiated mice.[8] The reconstitution of recipient lymphohematopoietic structure and function by donor cells was documented by 1955.[9,10] Insight into the immunogenetic restrictions of BMT, the syndrome of graft-versus-host disease, and the genetic combinations in which such secondary disease was or was not seen evolved rapidly.[11-13]

This early basic research was intended to develop BMT as therapy for patients accidentally exposed to lethal doses of irradiation. Mathe' and colleagues treated four Yugoslavian physicists with aplastic anemia from a radiation accident with intravenous BMT from unrelated donors.[14] Thomas treated a patient accidentally exposed to 600 rads with bone marrow from his identical twin.[15] Clinical BMT for leukemia, following chemoradiotherapy, resulted in a few transient grafts but early death from marrow failure was universal.[16] In 1965 Mathe' reported the longest patient survival to date — 20 months.[17] These formative years defined certain guidelines and problems for successful BMT in man including the adequate dose of nucleated bone marrow cells (4-40 $\times 10^{10}$), the adequate dose of total body irradiation (TBI 450-600 rad) as therapy and immunosuppression, and the almost certain failure of histoincompatible marrow to engraft.

The dismal clinical experience of the early 1960s spawned a second major thrust in basic laboratory research. Thomas' group studied genetics and radiation biology in out bred dogs;[19] van Bekkum in monkeys;[20] Santos investigated immunosuppression in rats;[21,22] Mathe' studied unmatched marrow and tolerance in mice[23] and Trentin studied graft-versus-host disease (GVHD) and the murine hematopoietic microenvironment.[24]

The growing body of basic knowledge gave rise to the modern era of BMT in 1969 when patients with leukemia or aplastic anemia underwent BMT with immunogenetically matched sibling marrow and survived at least the acute period.[25,26] By 1972 a patient with relapsed acute lymphocytic leukemia treated with 1,000 rad TBI followed by BMT had survived longer than 18 months.[26] Successful treatment of aplastic anemia with antilymphocyte serum or with cyclophosphamide followed by BMT was also reported.[26,27]

Aplastic Anemia • Aplastic anemia is defined as pancytopenia accompanied by a hypocellular or acellular bone marrow. Severe aplastic anemia is usually fatal. An absolute granulocyte count of less than 500/mm^3 and a platelet count of less than 20,000/mm^3 place the patient at high risk of severe infection and bleeding respectively. Within this group of patients, long-term survival is only 20% and half die within six months.[28] The causes of aplastic anemia include hereditary disorders, eg, Fanconi's anemia, toxic exposure, viral agents, thymoma, and drugs. However, in most instances the etiology is obscure.[29]

For most cases the pathogenesis of aplastic anemia is probably secondary to defective or to depleted pluripotent stem cells.[30] A minority of patients may have suppression of stem cell function rather than depletion of stem cell numbers. Two patients transplanted with stem cells from a normal identical twin failed initially but BMT succeeded when repeated after immunosuppression of the recipients.[31-33] Allogeneic grafts have failed after preparative immunosuppression but the patients have recovered endogenous hematopoiesis.[34-36] Moreover, hematopoietic recovery has occasionally occurred in patients treated with immunosuppression alone.[37,38]

Although the cellular mechanisms of stem cell suppression are not well defined, some studies support the hypothesis that cell-mediated suppression of stem cell proliferation and differentiation may continue to aplasia in some patients. Early studies showed that mononuclear cells from aplastic patients suppressed erythroid and myeloid colony formation by normal bone marrow cells.[39-41] The addition of cortisol to granulocyte-macrophage colony-forming assay (CFU-GM) cultures from aplastic patients who had responded to steroid therapy increased colony growth. This result suggested that the suppressor cell population in these patients was steroid sensitive.[42] However, more recent studies have produced conflicting results.[41,43-47] Bacigalupo and colleagues reported a study in which CFU-GM increased after depletion of the bone marrow cells of E-rosette-forming cells in 10 of 20 patients.[48] Five of the patients responded clinically to high dose steroids and five responded to antithymocyte globulin.

Failure of a variety of accessory cells is another mechanism that may cause aplastic anemia. Lithium and androgenic steroids have resulted in hematologic improvement in a few patients.[49,50] Defective bone marrow stromal cells have been shown to result in aplastic anemia in the Sl/Sl^d mouse, whose stem cells are capable of normal proliferation and differentiation when transplanted into a mouse with normal stroma.[51] The bone marrow microenvironment is an area of intensive research; its pathogenesis in human disease is not yet defined.[52,53]

The pathogenesis of aplastic anemia is a crucial question for its therapy. At present the only method to replace defective or depleted stem cells is BMT.

However, more specific therapies such as selective depletion of cells suppressing stem cell function might be possible if the exact pathogenic mechanisms were known.

Therapy • Since severe aplasia still results in death for about 80% of untransplanted patients, the supportive care of potential BMT candidates requires careful attention to detail, and consultation with a transplant center is highly recommended. Red cell transfusions may induce alloimmunization and predipose the patient to graft rejection. Therefore, the decision to prescribe packed red cells may have major ramifications later in the clinical course. Platelet transfusions present many of the problems encountered with packed red cells. Low dose prednisone may decrease the tendency for small-vessel bleeding and the need for platelet transfusions.[54] Prophylactic granulocytes neither reduce infections nor prolong survival.[55]

Specific therapies for aplastic anemia have not had consistent success. Immunosuppression with high dose prednisone, ie, to 20 mg/kg/day, antilymphocycte or thymocyte globulin or cytotoxic drugs has ameliorated the pancytopenia in 30% to 40% of patients but has rarely normalized the peripheral blood counts.[37,38,48] Androgenic hormones are rarely effective in patients with severe acquired aplastic anemia because their effects depend upon residual stem cell function and the absence of inhibitors.[56,57]

A prospective study which compared supportive care and androgens with allogeneic BMT in patients with severe aplasia demonstrated a 57% survival with BMT and only 25% with supportive care.[58] Clearly, for patients with severe aplastic anemia who have histocompatible donors, BMT is the standard of survival against which other therapies must be compared.

BMT requires sufficient immunosuppression to ensure engraftment without irreversible damage to vital tissues. Cyclophosphamide alone had been used extensively in preparative regimens but rejection still occurred in 25% to 60% of patients.[59,60] Factors enhancing engraftment in aplastic patients include a higher cell dose (3×10^8 cells/kg) and no prior transfusion of blood products.[61,62] Untransfused patients engraft 90% of the time and overall survival is significantly higher than for polytransfused patients.[61,62]

Both in vitro and serologic tests to identify patients presensitized by prior transfusions have been studied.[41,63-68] Measures to increase immunosuppression with antilymphocyte serum, procarbazine, total body irradiation, total lymphoid irradiation, or cyclosporin A have reduced the incidence of nonengraftment or rejection to a level of 10% to 20%.[69-73] Another successful approach has been to increase the number of stem cells in the graft by adding donor peripheral blood mononucelar cells in the days immediately following BMT.[74] Unfortunately, both approaches have increased the morbidity with an increased incidence of infection, interstitial pneumonitis, and/or GVHD.[69-74] Unfortunately, the mortality associated with immunosuppression and GVHD has almost replaced the mortality associated with rejection for presensitized patients.

Poor prognostic factors for survival in patients with sustained engraftment are related to severe GVHD, increasing age, and refractoriness to random donor platelets.[75] The use of lamiar air flow (LAF) rooms with gut decontamination and sterile food has been associated in one recent analysis with better survival and a lower incidence of moderate to severe GVHD.[75] Since patients who are febrile and infected at presentation are not placed in LAF, a selection bias may account for the apparent favorable results in LAF. The role of the sterile, protected environment remains controversial.

Improved survival of aplastic patients may ultimately depend upon definition of the pathophysiology for each case and formulation of appropriate specific therapy. Currently, BMT offers the best chance of survival and success depends upon early referral.

Patients with newly diagnosed, severe aplasia and with a suitable HLA-matched sibling are the highest priority for emergency admission to the five-bed Bone Marrow Transplantation unit at the University of Florida in Gainesville. The improved survival of patients who have received no or minimal transfusions mandates the urgency to refer these individuals for transplantation. Patients must also be free of active infection, be under age 30, and have adequate financial support to undergo transplant. For patients without an HLA-matched donor or with chronic aplasia, therapy with antilymphocyte globulin (ATGAM) is available on an experimental protocol.

Acute Leukemias • Acute leukemias are characterized by the rapid proliferation of malignant cells which phenotypically resemble precursors of normal lymphohematopoietic cells. The morbidity and mortality from leukemia is due either to preemption of normal hematopoiesis or to the infiltration of normal tissue by malignant cells.[76] Clinical improvement depends upon a decrease in maligant cells and the restoration of normal hematopoiesis.

The therapeutic objectives are based upon two assumptions: that cells capable of normal proliferation and differentiation coexist with the malignant population and that the normal cells can repopulate the patient when sufficient numbers of malignant cells have been destroyed. Alternatively, the malignant cell itself may be capable of normal differenti-

ation after sufficient numbers are killed by cytotoxic therapy, or normal differentiation of the malignant cell may be induced by chemotherapeutic agents. Data support both hypothesis.[77-81] Cytotoxic drugs induce transient complete remissions in 70% to 90% of leukemic patients. Durable complete remissions are attained by the majority of children with acute lymphocytic leukemia (ALL)[82,83] and in about 20% of adults with acute myelogenous leukemia (AML).[77-79] Despite these advances, the majority of patients with AML and subgroups of patients with ALL eventually die from recurrent leukemia.

Prognostic factors can define subpopulations of patients at highest risk of failure to achieve a cure with conventional regimens. Acute lymphocytic leukemia patients less than 15 years of age with white blood counts less than 20,000/mm^3 and no organ infiltration and with leukemic cells phenotypically positive for the common ALL antigen (CALLA) have a 70% chance of cure with chemotherapy. However, older children or those with a high leukemia cell burden reflected by higher white cell counts and/or organ infiltration or those with leukemic cells of T-cell or pre-B-cell origin have a 20% to 40% chance of cure.[84,85] The prognosis for adults with ALL is dismal — about a 20% long-term survival. For AML prognostic features are less well defined. Fever and infection at presentation, high leukemic cell count, and age greater than 50 may be poor prognostic indicators. However, the survival and duration of remission in some studies has been reported to be similar despite advancing age,[79,86-88] while others have reported major survival differences according to age.[89]

Leukemia cell ablation followed by stem cell replacement (BMT) is an area of promising research. Recent developments in broadening the genetic boundaries, reducing the consequences of immunosuppression and of GVHD and reducing the risk of recurrent leukemia are discussed below. AML and ALL are discussed separately because many of the obstacles presented by the biology of these diseases differ.

Acute Myelogenous Leukemia • In 1977 the Seattle group reported 54 patients with AML transplanted while in relapse and with disease refractory to conventional chemotherapy. Although there were early deaths with GVHD, opportunistic infection or refractory leukemia, 22 of these end-stage patients attained complete remission.[90] Six patients have remained in continuous complete remission seven to 11 years after BMT.[91] None of these patients has received any additional antileukemic therapy following BMT. Other studies with relapsed patients had similar encouraging results.[92,93]

The apparent cure of a few end-stage patients proved that sufficiently intense chemoradiotherapy can ablate the leukemic clone and that BMT can restore normal hematopoiesis with donor cells. Application of these principles to patients in second or subsequent remissions improved the two-year actuarial survival rate to the 30% level. Although early death from toxicity, GVHD, and the consequences of immunosuppression remained high, BMT during complete remission yielded superior results to BMT in relapse.[94-96]

The application of the therapeutic concept of intensive chemoradiotherapy with marrow rescue to patients with AML in first remission has yielded the best results[95-103] These patients presumably have a lower tumor burden, are less likely to have refractory disease, and are in better medical condition than relapsed patients.

In three sequential studies reported from Seattle, 138 patients with AML underwent BMT. The relapse risk in patients transplanted during first remission has been 16%. Overall survival beyond two years has been 70% for patients under age 20, 55% for patients aged 20-30, and 35% for patients aged 30-50. When nonleukemic causes of death are excluded, BMT during first remission has an 80% probability of eradicating the residual leukemic cells.[91]

BMT has been used to treat patients in second and subsequent remissions as well as in early first relapse. A recent report from Seattle analyzed the outcome of patients transplanted in first relapse, second remission, or in first relapse after an attempt to induce a second remission with conventional chemotherapy had failed.[104] Patients for whom no second induction was attempted and patients who had successfully entered a second remission had less chance of leukemic relapse (23% and 42% respectively) than had patients for whom reinduction had failed (74%). The probability of survival ranged from 24% in the relapsed patients to 10% in those for whom reinduction failed. Though not statistically different, the trend favored patients for whom no reinduction was attempted.[104] For patients not transplanted during first remission, therefore, it seems reasonable to use BMT early in first relapse rather than to attempt a second chemotherapy induced remission.

For patients with AML in first remission and in first relapse, the use of BMT resulted in only a 20% leukemic relapse rate. Wider application of BMT in the management of AML can increase the cure rate since the cytotoxic preparatory regimens are highly cytocidal for AML in first remissions. Well designed clinical trials comparing BMT with modern consolidation chemotherapy during first remission are needed in order to define the role of BMT in the management of patients with AML.

BMT has also been used successfully to treat preleukemia secondary to therapy for Hodgkin's disease[105] and acute myelosclerosis.[106] Mismatched allogeneic grafts for treatment of AML have had some success as well.[107] The opportunities for better outcomes are well defined. Deaths are due to GVHD, organ toxicity, and the consequences of immunosuppression. The challenge is to develop safer regimens that retain the antileukemic effect.

The University of Florida BMT unit has an active transplant program for patients with acute myelogenous leukemia. As members of the Southeast Cancer Study Group (SECSG), we are one of the major BMT referral centers for patients with AML participating in a trial which compares state of the art, intensive cytotoxic therapy to BMT during first remission. This study is open to young (◄ 50 years) patients with newly diagnosed and untreated AML. Patients entering first remission are allocated to BMT if they have a suitable donor, are less than age 35, and have adequate financial support. Patients on this important study are admitted electively to our unit with a very high priority. Patients with AML in first remission who are not on the SECSG study are admitted with a high priority. Patients in first relapse, second or subsequent remission are accepted with a lower priority than patients with AML in first remission.

Acute Lymphocytic Leukemia • In 1977 the Seattle group reported the results of BMT in 46 patients with recurrent, refractory ALL.[90] Six patients remain in complete remission eight to 11 years after transplant.[108] Although the results of BMT during second and subsequent remissions vary, survival at one to three years is about 30% to 50% for patients in second remission and 10% to 30% for patients in third remission.[101,109-113] Despite the low survival and high rate of leukemic relapse, comparisons of BMT during second remission demonstrate longer relapse-free survival than for patients in second remission receiving continued chemotherapy.[108,110,111]

The prognostic factors that predict poor outcome after BMT are similar to those that predict poor outcome at first presentation. Obviously, it is difficult to use these parameters to select optimal candidates for BMT.

The experiences with BMT during first remission of ALL is limited to patients with poor prognostic indicators. Although the series are small and follow up is short, BMT in first remission may have a survival advantage due apparently to a lower rate of leukemic relapse. If correct, these data are consistent with the trend seen for BMT in third remission versus second remission.[107]

The major obstacle to successful BMT for patients with ALL is leukemic relapse. The mortality associated with more intense preparative regimens has precluded improvement in overall survival rates.[114] New approaches are presently under study. By combining several drugs with TBI and by substituting cyclosporin A for GVHD prohylaxis, the Westminister group has achieved an actuarial survival for patients transplanted in first, second and third remission of 78%. None of five patients undergoing BMT in first remission has relapsed.[111] In a preliminary report the Cleveland group had eight of 13 patients alive between two and 20 months after BMT when prededed by high-dose cytosine arabinoside and fractionated TBI.[115] Novel approaches both to pre- and post-BMT therapy are needed to overcome the problem of leukemic relapse.

The potential of BMT in the management of ALL has not yet been realized. BMT has cured some patients with refractory ALL and offers some benefits in terms of disease-free survival for patients in second or subsequent remissions. The standard preparative regimen using cyclophosphamide and TBI and the standard post-BMT regimens using short-term methotrexate appear to be inadequate to prevent leukemic relapse in patients with high white counts at initial presentation.[110] Well constructed clinical trials using novel approaches to therapy will be needed to determine if BMT offers an increased probability of cure to poor prognosis patients while they are in first remission.

At the University of Florida, adults and children with acute lymphocytic leukemia in second remission or children with ALL with poor prognostic indicators who are in first remission are candidates for BMT. Patients in third or subsequent remissions are carefully considered on a case by case basis.

Chronic Myelogenous Leukemia • Chronic myelogenous leukemia (CML) is characterized by a clonal expansion of hematopoietic cells and has two distinct phases. During the chronic (stable) phase morphologically immature granulocytic and erythrocytic elements circulate in the peripheral blood. Chromosome analysis of bone marrow cell metaphases reveals the characteristic Philadelphia (Ph') chromosome in 85% of patients. Clinically patients are frequently asymptomatic or may have nonspecific constitutional symptoms. After a median duration of three years the chronic phase evolves into blast crisis which mimics the acute leukemias both morphologically and clinically. Some investigators have attempted to define an intermediate phase, termed accelerated disease, which heralds the onset of blast crisis. Criteria have included apparent refractoriness to conventional chemotherapy, thrombocytosis, enlarging hepatosplenomegaly, worsening anemia, and new chromosomal abnormalities. The imprecise definition of acceleration results in considerable variation of patient popultions from

center to center. In addition, one third of patients evolve into blast crisis without entering the "accelerated phase".

Attempts at therapeutic intervention during the chronic phase have included whole body irradiation, radioactive phosphorous, splenic irradiation, splenectomy and chemotherapy with single or multiple agents.[116-122] None of these modalities is curative although chemotherapy may delay the onset of blast crisis. Treatment for blast crisis is dismal. After intensive chemotherapy, a few patients enter a second chronic phase which is usually short lived. Conventional chemotherapeutic strategies are not curative.

During the 1970s marrow transplantation was attempted as treatment for blast crisis.[123-125] Reports from several transplant centers demonstrated a high early morbidity and mortality. In addition to infection, interstitial pneumonitis, and GVHD, early leukemic relapse occurred in high proportion of patients. However, approximately 10% of patients transplanted during blast crisis survived disease free for one year and a small number of five year survivors have been reported. This early experience demonstrated the curative potential of BMT for CML.

Fefer et al published a series of 12 patients with chronic phase CML who underwent syngeneic BMT.[126] Although one patient died early from interstitial pneumonitis, 11 attained normal peripheral blood counts and had Ph' negative marrow chromosome examinations. Three patients, one of whom entered blast crisis and died, had reemergence of the Ph' chromosome. Eight patients remain in complete hematologic and cytogenetic remission. This experience demonstrated that BMT during chronic phase CML is feasible without excessive early mortality. More importantly, BMT during the chronic phase clearly has the potential for cure.

Allogeneic BMT has been performed in over 200 patients with stable or accelerated phase CML.[127] In a composite analysis of early results from several centers, BMT during the "accelerated" phase carried a higher morbidity and mortality rate than BMT during the chronic phase. The disease free survival for patients transplanted in acceleration was 36% compared to 70% in stable phase. Although the precise reasons for these differences are not clear, a higher leukemic cell burden, more prolonged exposure to drugs, especially alkylating agents, and/or poorer general medical condition are possible explanations.[131, 132]

Current data indicate that both syngeneic and allogeneic BMT for chronic phase CML is potentally curative but four important questions await answers. First, which patients with CML should be transplanted? That is, is there an age beyond which the risk of early BMT related complications is too high? Can partially HLA mismatched donor marrow be used after in vitro purging of immunocompetent cells?

Second, the mechanics of BMT need refining. Does the spleen represent such a large repository for leukemic stem cells that pretransplant splenectomy would be advantageous? As suggested by some investigators, are cytotoxic modalities alone sufficient to ablate the leukemic clone? If so, which drug(s) is (are) most efficacious and have the least toxicity? Is radiotherapy required and what is the optimal delivery technique? If there is a graft versus leukemia effect in CML analogous to that observed in acute leukemia, can GVHD be modulated without undue morbidity?

Third, the timing of BMT for CML is particularly important since asymptomatic patients with a good short-term prognosis risk early death from BMT complications. Can good prognosis subpopulations from whom BMT can be delayed without risking blast crisis be identified? Should all patients with a suitable donor undergo BMT immediately after diagnosis?

Finally, the true relapse rate must be defined. Long-term follow-up is needed before actual relapse rates and cure rates are known. These questions require answers by well-designed clinical trials before the role for BMT in CML becomes well defined.

Since BMT offers the only realistic chance for cure for patients with CML, these patients are given a very high priority for admission to the University of Florida BMT program. Our present policy encourages BMT during the chronic phase of CML. Since the risk of entering blast crisis is relatively low during the first year after diagnosis, we recommend transplant after approximately one year of medical management. The one exception is patients with marrow karyotypes negative for the Philadelphia chromosome. These patients have a much worse prognosis and are transplanted in our unit as soon after diagnosis as possible. Patients with Philadelphia chromosome positive CML in stable phase beyond one year are transplanted electively with a very high priority. Patients in the accelerated phase are candidates for BMT with a priority below patients in chronic phase. We do not recommend allogeneic BMT for patients in blast crisis because of the very high early mortality. Additional criteria for patients with CML to under BMT include the absence of active infection, age less than 30 years, and adequate financial support.

Summary • Basic and applied research has made BMT available as a therapy with curative potential for patients with aplasia or with hematologic malignancy. Before BMT can be a safe and widely applied therapeutic modality, four major conceptual challenges must be overcome.

First, more selective means of immunosuppression and/or new methods to accelerate immunologic reconstitution are needed to preserve the patient's ability to resist infection.

Second, more selective cytotoxic therapy to destroy the residual leukemia cells may improve overall survival of leukemia patients.

Third, the boundries of genetic restrictions must be expanded beyond those of the histocompatible sibling.

Fourth, new methods of selective removal of the immunocompetent cells responsibile for GVHD or selective enrichment of pluripotent stem cells may facilitate engraftment and minimize the risk of GVHD.

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Cancer treatment using autologous bone marrow infusions

John Graham-Pole, M.D., MRCP and Adrian Gee, Ph.D.

Infusion of bone marrow can circumvent the major dose-limiting factor of intensive chemotherapy given to patients with cancer. For autologous marrow transplantation, a small fraction of the patient's bone marrow is aspirated and frozen for reinfusion after completion of treatment. The rationale behind autologous bone marrow transplantation for acute leukemia and for nonhematologic cancer differs. The purpose in acute leukemia is to eradicate all hemopoietic stem cells, both leukemic and normal. In other cancers, complete elimination of marrow stem cells is not needed, and both residual and infused stem cells may be responsible for hemopoietic recovery.

Interest in autologous bone marrow transplantation developed after the Seattle group showed that transplantation from HLA-identical siblings could achieve long-term disease-free survivals in patients with leukemia refractory to conventional therapy.[1,2] Intensive cytoreductive regimens consisting of total body irradiation (TBI) and high-dose chemotherapy followed by bone marrow infusion were developed for the management of refractory cancers.[3,4] The value of allogeneic bone marrow transplantation is limited by availability of donors, graft-versus-host disease, and interstitial pneumonia.[5,11] Autologous bone marrow transplantation is, therefore, an important alternative for such intensive treatment regimens.

There have been several studies using autologous bone marrow transplantation in patients with leukemia and other cancers.[12-14] The initial studies concentrated on cancers refractory to conventional treatment; lately this therapy has been used to enhance responses in patients with minimal residual disease.

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Methods • For an autologous marrow transplant, cells are usually obtained by multiple bone marrow aspirations from the posterior iliac crest under general anesthesia. One to three pints of bone marrow blood are aspirated using multiple sites and the red cells are removed by centrifugation. An average yield of 2.5×10^8 nucleated cells/kg is obtained, which is usually sufficient for two autologous reinfusions.

Bone marrow cryopreservation has been extensively reviewed in recent years.[15-18] Most studies have used dimethylsulfoxide (DMSO) in a final concentration of 10% and autologous or heterologous serum. A freezing rate of 1 C/minute results in good viability of bone marrow CFU-C.[18] Bone marrow is stored in the liquid phase (-196 C) or vapor phase (-80 C) of liquid nitrogen. In the dog, storage in the vapor phase leads to decreased viability over several years.[18] Step-wise dilution of cells after thawing washes off the cryopreservative without causing osmotic shock to them.[19] Combining DMSO and hydroxyethylstarch may be even more effective. Infusing between 5×10^7 and 1×10^8 nucleated bone marrow cells/kg body weight probably suffices for hematopoietic recovery, assuming good cell viability.

Autologous marrow infusions in acute leukemia • Several factors determine the outcome of autologous marrow infusions in leukemia patients: (a) how completely the leukemia has been eradicated in vivo; (b) the presence of residual leukemic cells in the stored marrow collected during remission; (c) the viability of the cryopreserved marrow.

Can lethal antileukemic treatment be effective when followed by "rescue" with frozen autologous bone marrow? Evaluating this new method needs three steps: (a) test its feasibility for patients in relapse to determine if cryopreserved marrow can restore hematopoiesis after cytoreductive treatment and can achieve remissions; (b) examine whether complete remission and survival rates are longer after autologous marrow infusions than after conventional chemotherapy in refractory patients; (c) evaluate autologous marrow infusions in first remission in a Phase III type of controlled prospective study, for example, in patients with acute leukemia who have a poor prognosis on the basis of presenting features of their disease.

Acute leukemia in relapse • Table 1 shows some of the cytoreductive regimens that have been used in leukemia patients undergoing marrow autografting. Most experience has been with a combination of cyclophosphamide and TBI.[20] VM-26, cytosine arabinoside (CCV)[21] BCNU, daunorubicin, 6-thioguanine, VP-16 and piperazinedione,[22] with or without TBI, have also been tested. About 65 patients with acute myeloblastic leukemia (AML) in relapse have been treated in several studies. About two thirds achieved complete remission. The median response duration was six months. About 30 patients with acute lymphoblastic leukemia (ALL) in relapse have been studied at several centers with complete remissions in about half and a median duration of three months.[22-24]

Acute leukemia in remission • Since a few long-term unmaintained remissions have been obtained in relapsed patients, a similar approach has been taken for patients in remission (Table 2). The Seattle

TABLE 1. — CYTOREDUCTIVE REGIMENS USED WITH BONE MARROW AUTOGRAFTING IN LEUKEMIA.

Chemotherapy	TBI	Institution
Cyclophosphamide	Yes	Seattle, St. Louis, Baltimore, Minnesota
Daunorubicin, cytosine arabinoside, 6-thioguanine, VP-16	Yes	London
Piperazinedione	Yes	Houston
VM-26, cyclophosphamide, cytosine arabinoside	Yes	Boston
6-thioguanine, cytosine arabinoside, cyclophosphamide, CCNU	No	Besancon

TABLE 2. — BONE MARROW AUTOGRAFTING FOR PATIENTS WITH ACUTE LEUKEMIA IN REMISSION.

	Number of Patients	Remission Status	In Vitro Treatment of Bone Marrow	Remission Duration (Months)	Long-term Survivors	Early Deaths	Centers
ALL	29	1st-4th	Yes	3-42+	5 (22-42+)	5	Boston, UCLA, Baltimore, Houston
AML	22	1st-2nd	No	0-41+	4 (12-41+)	2	Seattle, St. Louis, Houston, Besancon

group transplanted ten patients with AML in first remission. Eight patients achieved complete recovery and four are in continuous complete remission up to three years. Fewer patients have been transplanted in St. Louis and in Besancon with occasional complete remissions lasting several years.[24]

Nine ALL patients in Boston underwent marrow autografting in second remission.[21] The marrow was treated in vitro with anti-CALLA monoclonal antibody. Seven achieved complete remission with a median duration of seven months. Kaiser et al treated four children with cyclophosphamide and TBI followed by infusion of autologous marrow, treated in vitro with anti-Leu-1 monoclonal antibody, the remissions lasting between three and 26 months.[25] Twenty-six patients were treated in Houston with an intensive induction regimen followed by marrow autografting. Only two of the 14 patients who reached the intensification phase remain in continuous complete remission, with overall median remission durations of four months for ALL and six months for AML.[26] However, less than 10% of patients who received autografts for either AML or ALL with unpurged bone marrow are in continuous complete remission for more than two years, which may be because of weakened immunity after transplantation or contamination of the infused marrow with leukemic cells.

Autologous marrow infusions for chronic myelogenous leukemia (CML) • Nucleated cells from marrow of newly diagnosed patients with CML have been used for hematopoietic rescue after ablative therapy in the terminal phase of their disease. The Seattle group treated seven patients in blast crisis with cyclophosphamide and TBI and reinfused marrow cryopreserved during chronic phase.[1] Only two patients had a complete engraftment and a second stable phase. In London the Hammersmith group used combination chemotherapy with and without TBI, achieved second stable phase for an average of four months duration in 32 of 33 patients.[27] Autologous reinfusion for CML in blast crisis is, therefore, a feasible method of palliation which produces occasional long-term survivals.

Autologous marrow infusions in nonhematologic cancers • Bone marrow autografting for nonhematologic cancer must address two questions: Is there sufficient dose-related response in different cancers to justify such extreme dose escalation? Can bone marrow autografting after ablative therapy improve hematopoietic recovery enough to lessen morbidity?

Several animal studies show drug-dose-responsiveness,[28] most drugs showing a steep response curve for toxicity and therapeutic effect. However, there have been few controlled studies examining the question in humans. Cohen et al compared two dose levels of cyclophosphamide, CCNU, and methotrexate in oat cell lung carcinoma and found greater response rate and longer median survival with the higher dose regimen.[29] Others have found that higher dose maintenance regimens achieved longer remission durations in ALL.[30]

Highly sensitive cancers are potentially good models for marrow autografts. These include malignant lymphomas, Ewing's sarcoma and neuroblastoma, small cell lung carcinoma, ovarian, breast, and testicular carcinomas. Several studies have documented the activity of high-dose chemotherapy in refractory cancer (Table 3). Appelbaum et al used a high-dose combination regimen together with cryopreserved autologous marrow to treat patients with Burkitt's and histiocytic lymphoma.[31] There were several responses and four patients with Burkitt's lymphoma are long-term survivors. The Johns Hopkins group treated children with refractory cancer using high dose combination chemotherapy consisting of hydroxydaunomycin, cyclophosphamide, and TBI. One patient with Burkitt's lymphoma achieved long-term disease-free survival.

These studies show that long-term survival and possibly cure can be achieved in patients who would almost certainly have failed conventional chemotherapy. The question remains how marrow autografting will fit into the overall treatment of drug-responsive cancers.

Malignant lymphoma • Although many patients with Hodgkin's and non-Hodgkin's lymphoma can be cured with current therapy, many still relapse and are good candidates for marrow autografting.

Initial studies showed good responses to high-dose combination chemotherapy[31] using cyclophosphamide, vincristine, and methotrexate. Recently a

TABLE 3. — CYTOREDUCTIVE REGIMENS USED WITH BONE MARROW AUTOGRAFTING IN NONHEMATOLOGIC CANCERS.

Cytoreductive Therapy	Number Patients	Diagnosis	Long-term Survivors
BCNU, Ara-C, cyclophosphamide, 6-thioguanine	22	Diffuse lymphomas	2 (►2 yrs)
Melphalan, ±TBI ±TBI	28	Neuroblastoma and melanoma	2
Cyclophosphamide, BCNU, VP-16	19	Small cell lung and testicular carcinomas	1
Cyclophosphamide, hydroxydaunomycin, vinblastine, TBI	15	Lymphomas and sarcomas	3

French group reported on 18 patients with refractory lymphoma treated with cyclophosphamide, TBI, and autologous marrow rescue. Ten patients achieved complete remission, of whom four remained in complete remission for 14-46 months.[32] The role of high-dose cytoreductive treatment and autologous rescue can now be examined in patients with less advanced disease.

Poor prognosis patients, eg, those with diffuse lymphoblastic, undifferentiated or histiocytic lymphomas, with initial bone marrow and CNS involvement are candidates for marrow autografts in first remission. However, in vitro purging of the remission marrow is probably necessary. Monoclonal antibodies are available for characterizing the non-Hodgkin's lymphomas, and the feasibility of treating marrow with monoclonal antibodies and complement has been studied in ALL using anti-Leu and anti-CALLA antibodies with rabbit complement.[21,25]

Small cell carcinoma of lung • Small cell lung carcinoma is highly sensitive to several single agents and the M.D. Anderson group have conducted several therapeutic trials in this cancer.[33,35] High-dose combination chemotherapy consisting of cyclophosphamide, BCNU, and VP-16 has produced a significant response rate in refractory patients.[32] In later studies, primary intensive induction was followed by normal dose maintenance, hoping to prevent drug resistance and achieve better tolerance for high-dose therapy in untreated patients.[34] High-dose hydroxydaunomycin, cyclophosphamide, vincristine and VP-16 were followed by prophylactic brain irradiation and maintenance therapy with four courses of hydroxydaunomycin, cyclophosphamide, vincristine, and VP-16 in maximally tolerated doses. The median response duration for 13 patients was nine months. Seven achieved complete and six partial remissions. Normal hematopoiesis was seen three weeks after bone marrow autografting.

Marrow autografts were then used for intensification.[34] Induction chemotherapy consisting of three courses of vincristine, ifosfamide and hydroxydaunomycin, was followed by high-dose VP-16, cyclophosphamide and methotrexate with folinic acid rescue. Four of ten evaluable patients achieved complete remissions after induction. After two courses of high-dose intensification, seven had complete and two partial remissions with response durations from 1-10+ months.[34,35]

In another study, induction with cisplatinum, hydroxydaunomycin, and VP-16 was followed by intensification with the same drugs, but only two of 13 patients had long-term disease-free survival.[36] Souhami et al[37] treated 16 patients with high dose cyclophosphamide (160 to 200 mg/kg) with later irradiation to the site of primary disease. Full hematopoietic recovery was reached by 21 days. Six patients are reportedly in continuous complete remission from seven to 12 months.

Overall, marrow-ablative therapy with autologous marrow rescue has not significantly improved disease-free survival in patients with small cell lung carcinoma due either to limited dose response, use of the wrong drugs, or bone marrow contamination at the time of collection. Alternative high-dose regimens and purging of harvested marrow may overcome these problems.

Neuroblastoma and Ewing's sarcoma • Disseminated neuroblastoma has a response rate and proportion of long-term survivors similar to small cell lung carcinoma. High doses of melphalan (90 to 220 mg/m^2) often produce further responses in otherwise refractory patients.[38,39] This has been used as intensification in a group of 12 children who received initial induction with cyclophosphamide, vincristine, and hydroxydaunomycin.[38] Seven patients showed further tumor shrinkage with high-dose melphalan (140 mg/m^2) and there were three disease-free survivors 33+ to 80+ months at the time of the report. This approach is promising but needs confirmation in controlled studies.[39] A major concern is the frequent neoplastic marrow infiltration but several monoclonal antibodies are available which may be useful for purging in vitro.[40] The Pediatric Oncology Group is currently comparing autologous and allogeneic marrow transplantation in children with neuroblastoma in first remission and at a later stage of their disease.[41]

Ewing's sarcoma of children is highly drug-responsive but has a high relapse rate. High-dose melphalan has been given to eight children with refractory Ewing's sarcoma followed by autologous marrow rescue.[39] Six patients achieved partial remissions for a median duration of three months.

Autologous marrow purging • The failure of ablative therapy followed by autologous bone marrow to produce prolonged disease-free survival in most patients suggests that the autologous marrow may contain occult neoplastic cells. In vitro methods are, therefore, being developed to identify and eradicate such cells from the marrow. They may be divided into those in which cancer cells are physically removed and those in which they are destroyed in situ.

Physical removal techniques • Two procedures for physical removal have been tested: differential centrifugation on albumin density gradients;[42,43] linking the contaminating cells via antibodies to magnetite-rich microspheres and extracting them using electromagnets.[44,45]

The use of albumin density gradient centrifugation[42] is based on the observation that leukemic cells are lighter than normal marrow progenitor cells (CFU-C).[46] Dicke and his associates have compared gradient-purged and nonpurged autologous marrow in ALL, AML and AUL in two reports.[42,47] Erythrocyte-depleted marrow suspended in 17% bovine serum albumin is centrifuged on a discontinuous gradient of 21%, 23%, and 25% BSA at 1000g for 30 minutes at 10C and the cells at each interface are collected separately. Only the cells from the two denser interfaces and those that passed completely through are then reinfused, representing 96%; of the CFU-C. Certain problems exist. It is impossible to determine how efficient this procedure is in cases of occult marrow infiltration. The density differences between malignant and normal cells probably vary in individuals making the separation conditions hard to standardize. Because of the small population studied and short follow-up time, we cannot yet judge the value of this procedure. Of 21 evaluable patients[47] five of ten who received purged marrow had remissions lasting up to 14 months, while six of 11 receiving unfractionated marrow had remissions of up to eight months; this difference is not significant.

A very promising method for neoplastic cell separation has been developed at the Imperial Cancer Research Fund Laboratories in London. Kemshead et al have developed mouse monoclonal antibodies to human fetal brain that bind to tissues of neuroectodermal origin.[48] Using panels of these antibodies they have selected binding patterns to identify neoplasms of different histological types. A new technique has been used to remove the antibody-coated neoplastic cells.[45] The marrow is mixed with magnetite-containing polystyrene microspheres coated with sheep antimouse immunoglobulin binding the beads to the monoclonal-antibody-coated cells which are removed by passing the marrow over samarium-cobalt and electromagnets to which the beads adhere. In experiments in which tissue-cultured malignant neuroblasts were seeded into marrow to produce a 1%; infiltrate, 99.9% of the tumor cells were removed with the magnetic microspheres.[44] This is at the limit of resolution of all methods available for determining neoplastic contamination of marrow. In four patients with infiltrates of 0.1% to 3.0%, there were no neuroblasts detectable by immunofluorescence, histological or cytological methods.[45] About 70% of the buffy coat cells were recovered with a viability of 98%. The entire procedure from collection of the marrow to cryopreservation takes eight hours.

At this stage, the magnetic separation method seems the most promising of all techniques currently under investigation for marrow purging. It should be widely applicable to different types of cancer simply by varying the antibody panel.

Destruction of tumor cells in situ • Methods that aim to destroy cancer cells rather than remove them rely on identifying these cells selectively in the presence of large numbers of normal hematopoietic cells. The restricted antigenic composition of the cells in the infiltrated marrow means that the antibodies need not be tumor-specific but need only bind to a determinant expressed selectively on the cancer cells. Although heterologous antisera have been used they often require extensive absorption to reduce their cross-reactivity with normal cells. This can be avoided by using the monospecificity of monoclonal antibodies. Combining various antibodies broadens their specificity so that hopefully all neoplasms of a particular histological type can be detected. Panels have already been developed to identify leukemias and neoplasms of neuroectodermal origin.[48] The cells that bind antibody can be killed either by linkage of a toxin to the antibody ("immunotoxin" purging)[49] or by adding serum complement to the marrow,[50] as described later.

Other nonimmunological methods have also been described. The most frequently used technique is to incubate the marrow with tumoricidal concentrations of cytotoxic drugs. The obvious limitation is the toxicity of the drug to hematopoietic stem cells. Most studies of this approach have used an analog of cyclophosphamide, 4-hydroperoxycyclophosphamide (4HC).[51,52] Preliminary experiments showed that 4HC could eliminate rat AML cells without destroying all pluripotent stem cells.[51] The toxic effects of 4HC on CFU-C are known to depend on dose and leukocyte concentration, and it has been reported that a maximal loss of 80% of CFU-C can be tolerated without impairing hematological reconstitution.[53]

Conflicting reports have appeared on the value of another metabolite of cyclophosphamide, Asta Z-7557. One group has reported that this drug shows similar levels of toxicity towards both human leukemic clonogenic cells and hematopoietic progenitor cells.[54] Others have described a differential effect and indicated lower cytotoxicity towards CFU-GM than 4HC.[55] This discrepancy can be explained by recent work showing that although Asta Z (and 4HC)[55] may destroy most progenitor cells a small number can survive and proliferate during long-term (Dexter) continuous bone marrow culture.[56] It is these resistant cells that are probably responsible for hematological reconstitution.

Asta Z has been used clinically in several centers. Nine patients in France with acute leukemia whose marrow was treated using concentrations of 60-80uM Asta Z showed a delay in engraftment of about one week and a low (10%) recovery of committed stem

cells. However, eight patients remained in complete remission of up to 16 months duration at the time of the report.[54,55]

Promising laboratory results have been obtained with two other drugs. VP-16-213 is reportedly more toxic to leukemic cells in vitro than 4HC, without an accompanying increase in stem cell toxicity.[57] For treatment of neuroblastoma-contaminated marrow the combination of 6-Hydroxydopamine and ascorbate has been shown to be efficient in tissue-culture studies, particularly against catecholamine-secreting cells but has yet to be tested clinically.[58]

The preferential killing of neoplastic cells represents a narrow therapeutic index for many cytotoxic agents. This problem can be overcome by direct targeting of the toxic agent to the cancer cells by means of antibody. The most physiological approach is to use tumor-binding antibodies that will activate the serum complement system. In practice, although this technique is certainly feasible, we consider there are several problems to be solved before it should be used clinically. An alternative has been to couple a toxin directly to the tumor-directed antibody. The toxin most widely used for this purpose has been the lectin, ricin, derived from the castor bean.

Ricin consists of two disulfide-linked subunits (A and B) with very different properties.[59] The A chain inhibits protein synthesis of the cell by inactivating the 60S ribosomes. The B chain binds to galactose-containing receptors on the cell surface and accelerates the transport of the A chain to the ribosomes. The efficiency of ricin is such that a single molecule within the cytoplasm is sufficient to kill the cell.[49] Both the intact molecule and the isolated A chain have been linked to antibodies. The conjugates made with the whole toxin are more effective than those prepared with the A chain alone but must be used in the presence of lactose to block the galactose binding site on the B chain, thereby preserving the antibody-determined specificity of the immunotoxin.[60]

A chain immunotoxins have been tested in the laboratory for the treatment of mouse leukemia.[49,61] This immunotoxin has been used to purge BCL1 cells from mouse bone marrow at a 15% level of infiltration. Hematological reconstitution was seen in all animals treated and 17 out of 20 animals had not relapsed within three months, at which time all the control animals had leukemia.

A second animal model for the study of ricin immunotoxins has been developed by Thorpe and associates.[27] Their initial attempts to use A chain linked to a monoclonal directed against an antigen found on a variety of rat leukocytes, but not on rat bone marrow hematopoietic cells, proved unsuccessful. The variability in the efficacy of monoclonal antibody-A chain conjugates has been noted by many researchers, and has been attributed to differences in the ability of the surface antigen to mediate translocation of the ricin chain into the cytoplasm. To avoid this problem intact ricin was linked to the antibody and the conjugate incubated with experimentally-contaminated bone marrow in the presence of 100mM lactose to block the receptor on the B chain. The treated marrow was injected into sublethally or lethally irradiated animals. In lethally irradiated animals stem cell activity was compared to that in animals receiving a known innoculum of uncontaminated marrow. In both groups of animals there was good engraftment and the authors concluded that this immunotoxin could kill 99.0% of the leukemia cells while reducing stem cell activity by only one half.

Although the animal studies using ricin-based immunotoxins are promising, several problems must be resolved before widespread clinical application. A chain conjugates may take several days to kill CALLA-positive leukemia cells. Also, toxin may be liberated into the circulation, by release either from the conjugate or the toxin-killed cells. Such difficulties may be avoidable by using alternative toxins, and this is being pursued.

The ability of IgM and certain IgG antibody subclasses to fix and activate complement has been used as an alternative for eliminating antibody-coated cells in bone marrow. Although both heterologous and monoclonal antibodies have been studied, the trend has been to use multiple monoclonals which are mostly IgG antibodies. In contrast to IgM antibodies, a single IgG molecule on the cell surface cannot activate the complement cascade.[63] Methods that increase the density of IgG antibody on the cell could, therefore, dramatically increase complement activation. This can be achieved with multiple IgG monoclonals directed at a variety of determinants on the surface or by using staphylococcal protein A to form complexes of IgG molecules that then behave like IgM.[64]

In antibody- and complement-mediated purging the most frequently used complement source is whole rabbit serum because it is particularly efficient at lysing human cells. Different complement batches must be screened, however, as some contain natural antibody to determinants on normal marrow cells. This nonspecific toxicity is one of the main difficulties in using complement for purging. It can be reduced either by extensive absorption of the complement with normal marrow cells or by manipulating the composition of the complement. We are currently studying the latter technique in our laboratory. Toxic rabbit complement is diluted to a concentration at which toxicity is lost and the limiting components are then supplemented by the addition of partially purified nontoxic components from other species. This will hopefully allow us to

prepare large batches of standardized complement of low nonspecific toxicity having the ability to selectively lyse antibody-sensitized neoplastic cells.

Even with the availability of good antibody and complement sources several variables must be optimized. In both animals[65] and humans[66] single treatments with antibody and complement were less effective for killing leukemia cells than sequential treatments.[50] It is not clear why repeated treatments should be more effective than one, particularly as conditions were used which minimized modulation of the antigen on the leukemia cells.

In agreement with others, we have found that the phase of growth of cells in tissue culture also affects their sensitivity to complement-mediated killing.[66] This is independent of the level of antibody binding and probably relates to changes in composition of the cell surface. The presence of complement-resistant neoplastic cell subpopulations may prove an obstacle to marrow purging with antibody and complement. It may be possible to increase the susceptibility of these resistant cells by treatment with enzymes[67] or drugs[68] but the effect of such treatments on hematopoietic stem cells has still to be determined.

While conditions can be found under which 100% of tissue-cultured neoplastic cells can be killed by antibody and complement, this does not reflect the situation in the harvested marrow. For the purposes of purging, the antibody must be directed towards a tiny population of tumor cells in the presence of a vast excess of normal stem cells. Preliminary evidence suggests that complement-mediated killing of neoplastic cells is compromised by the release of anticomplementary factors from the normal stem cells.[69] The effects of this factor can be overcome either by increasing the complement concentration or by diluting the marrow before incubation. This may necessitate processing large volumes of marrow if full hematological reconstitution is to be achieved.

Most studies to determine the effect on hematopoietic stem cells of in vitro purging have relied on clonogenic assays or assays to committed progenitor cells, eg, the CFU-C and the BFU-E assays. The finding that marrow depleted of these precursor cells, by treatment with cytotoxic agents, is still able to produce complete hematological engraftment[52] highlights the problems of this approach. There is still no reliable in vitro assay for pluripotent progenitor cells.

A further difficulty associated with marrow purging techniques is to find a sensitive method to quantitate the efficiency of neoplastic cell removal. The most widely used methods are release of ^{51}Cr from prelabeled targets and the ability of viable cells to exclude trypan blue. At best these methods detect killing to two logs of neoplastic cells.[50] We have found that the results from the ^{51}Cr release assay are profoundly influenced by the method used to calculate the results.[70,71] We have, therefore, developed a rapid thymidine uptake assay that detects almost three logs of cell killing and is more sensitive than the 10-14 day neoplastic cell cloning technique. Until assays of similar or greater sensitivity are used, we should be wary of transferring laboratory conditions directly to the clinical situation. Methods such as fluorescence activated cell sorting[72] and long-term marrow culture, now being refined for the detection of residual neoplastic cells in treated marrow, will be vitally important for measuring the efficiency of marrow purging clinically.

Laboratory studies of antibody and complement have nonetheless produced encouraging preliminary results. It has been shown that lymphoma and leukemia cells in mouse[73,74] and rat[65] marrow can be selectively killed with little damage to hematopoietic cells. Experimental transplantation of complement-purged marrow in the rat resulted in disease-free 180-day survival of about half the treated animals, whereas all rats receiving nonpurged marrow died within 65 days.[65] The treatment did not damage either normal CFU-C or BFU-E. In human marrow, complement treatment killed 100% of carcinoma cells, as judged by ^{51}Cr release and trypan blue exclusion, without affecting CFU-C, BFU-E, Megakar or mixed erythroid/myeloid colony-forming cells.[75]

Clinically, complement has been used in the treatment of marrow from patients with leukemia and lymphoma.[76,77] Four patients with CALLA-positive ALL in relapse were transplanted with autologous marrow treated with monoclonal anti-CALLA antibody (J5) and rabbit complement.[76] All four engrafted, two of whom were in unmaintained remission one year after transplantation. Four children with advanced NHL in first remission received autologous marrow treated with anti-B-cell monoclonal antibody and complement.[77] All four engrafted and remained in unmaintained complete remission at the time of the report (1-17 months).

While these reports are encouraging, the use of antibody and complement for purging requires further basic research before it can be confidently applied clinically.

Conclusions • Autologous bone marrow reinfusions have been used as an investigational treatment for cancer. Stored marrow can reliably achieve hematopoiesis in vivo. Even though the complete remission rate after marrow autografting for relapsed leukemia is comparable to that achieved with syngeneic marrow transplants, there are fewer long-term disease-free survivors, suggesting that leukemia contamination of the autologous marrow is a limiting factor. Although in vitro marrow purging has been attempted with

cytotoxic drugs, physical separation, and monoclonal antibodies, the value of this treatment in leukemia remains to be established in controlled studies.

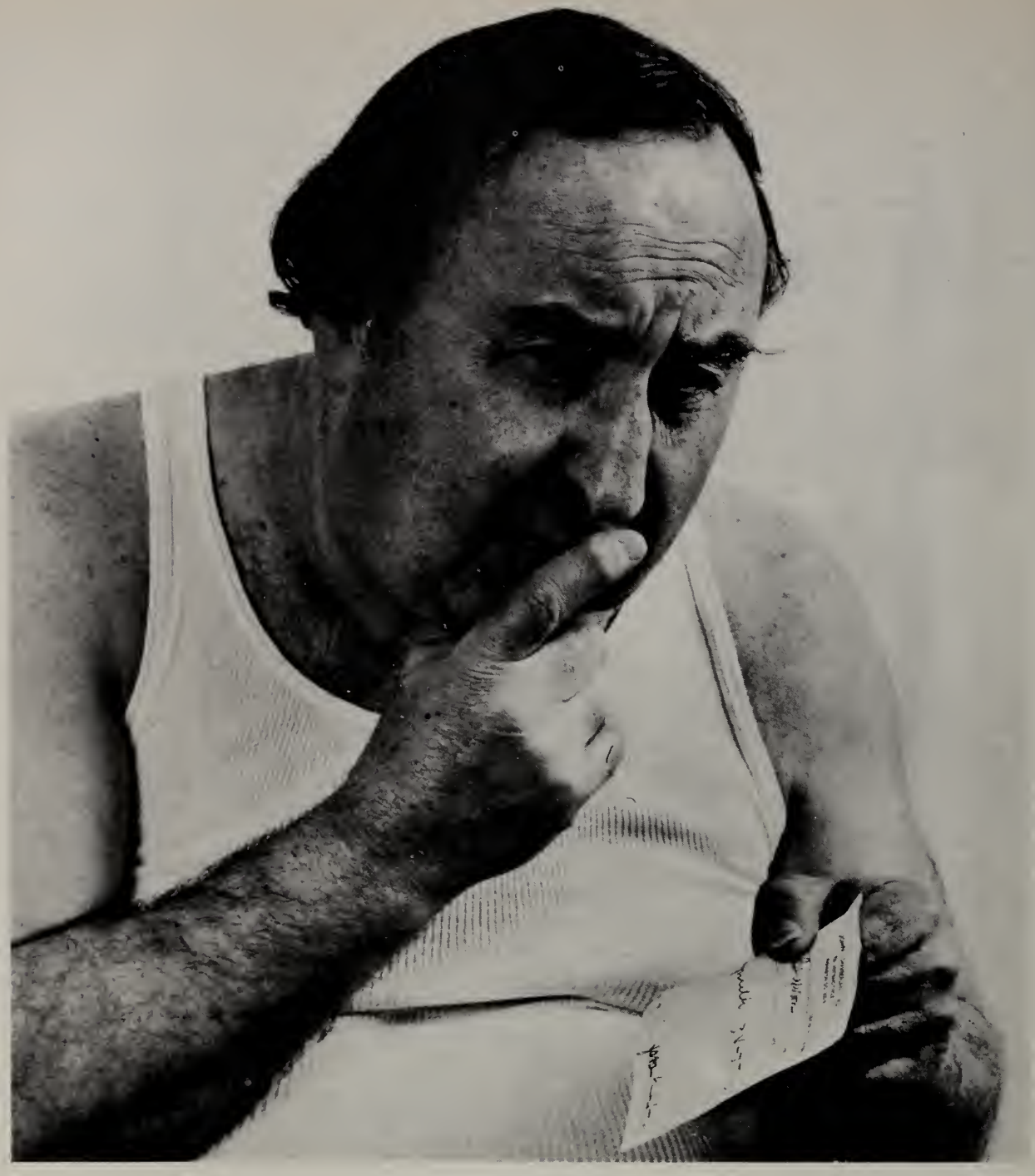
High-dose chemotherapy and autologous marrow infusion has produced long-term responses in lymphomas, lung and testicular carcinomas. The possibility of marrow contamination must similarly be addressed. There is great interest in high-dose chemotherapy and autologous marrow rescue as intensification in drug-sensitive cancers such as lymphoma, neuroblastoma, gonadal, bone, and perhaps breast cancer.

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(References available from the author upon request.)

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How well are you communicating with your PATIENTS?

Patient compliance—how well patients follow instructions about taking prescription drugs—is something that worries health professionals, according to a recent Harris survey. And with good reason. A number of studies have shown that a third to a half of all drugs are taken improperly. Yet a Chilton survey found that only 2 to 4 percent of patients question their doctors about drugs prescribed for them.

It's up to health-care providers to open up the dialogue about prescription drugs. When you write, dispense or check on a prescription, make sure your patient knows:

- **The name** of the drug
- **Its purpose**—what conditions does it treat?
- **How and when** to take the drug—and when to stop taking it
- What **food, drinks and other drugs to avoid** while taking it
- What **side effects** may result—are they serious, short-term, long-term, etc.?

■ *A message from the Food and Drug Administration.*

FLORIDA MEDICAL

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NOTES & NEWS

Tables turn on malpractice suit in Escambia County

Recovery of costs legislation was invoked recently when an Escambia County judge ordered two persons to pay the legal fees and other costs incurred by the defendants in a medical malpractice suit against West Florida Hospital and two doctors with the Medical Center Clinic.

John and Doreen Cato lost a suit in February against West Florida Hospital, Medical Center Clinic and two doctors. They were ordered to pay more than $40,000 in legal fees and other expenses.

Escambia County Circuit Judge Edward T. Barfield, denied a motion for a new trial by the plaintiffs in accordance with the jury's verdict. The judge ordered that West Florida Hospital, Inc., could recover $22,340.50 in attorney's fees and $1,898.29 in costs from the Catos.

Judge Barfield also ordered that the Medical Center Clinic, P.A., John E. Wimberly, M.D. and William C. Woolverton, M.D., could recover $14,111 in attorney's fees and $1,812.79 in costs from the plaintiffs.

Polaroid Photomicrography contest will award travel to scientific meetings

Travel to a technical or scientific meeting anywhere in the world will be among prizes awarded in the 1984 International Instant Photomicrography Competition announced by Polaroid Corporation.

This year's competition, Polaroid's third annual contest for microscopists who use instant photography to record images, offers three travel prizes worth up to $2,000 each. Other prizes include Polaroid 35mm instant slide systems, instant photomicrography systems, instant slide printers and Polaroid cameras.

The contest is open to light and electron microscopists throughout the world. Entries must be original, unpublished photomicrographs taken directly on Polaroid instant films, including Polaroid 35mm instant slide films.

Prizes will be awarded in three categories (1) light micrography on Polaroid instant color films, (2) light micrography on Polaroid instant black and white films, and (3) electron micrography on any Polaroid instant film. Winning entries will be published and exhibited throughout the world.

Seven countries were represented by winners of the 1983 competition. Contestants from Switzerland, the United States, Australia, Germany, Canada, the United Kingdom, and the Netherlands were awarded prizes.

Approximately 500 images were submitted by scientists, medical professionals, engineers, technicians and university students from 14 countries. Entries came from such diverse fields as medicine, biology, metallurgy, crystallography, electronics, criminology, textiles, and manufacturing.

Entries for the 1984 contest must be postmarked no later than October 5, 1984, and must be accompanied by an official entry form. Rules and entry forms can be obtained by writing to:

Polaroid Photomicrography Competition
575-9P Technology Square
Cambridge, MA 02139

May named National High Blood Pressure month

Recently released results of a 1982 survey conducted by the National Heart, Lung, and Blood Institute and the Food and Drug Administration portend a continued reduction in the deaths and disabilities from hypertension-related conditions. This survey showed that more Americans are aware of hypertension and its dangers, know that it can be treated effectively, and are getting their blood pressure checked than was shown in a survey conducted in 1973.

Results of the National Health and Nutrition Examination Surveys also show favorable trends. During the time period of 1971-72 to 1976-80, the

percent of hypertensives aware of their condition increased from 51 percent to 73 percent. In addition, control rates more than doubled during this period, from 16.5 percent to 34.1 percent.

Researchers regard these findings as encouraging and as an indication that the decline in stroke and heart attack mortality is likely to continue. During the decade following 1972, stroke mortality dropped by more than 40 percent, and heart attack deaths decreased by nearly 30 percent. Officials of the National High Blood Pressure Education Program, the program that coordinates national efforts to control high blood pressure, point out that the increased number of hypertensives under effective treatment have contributed to these trends.

The National High Blood Pressure Education Program was created in 1972 to work with community groups, volunteer organizations, medical specialists, and industry to maintain a steady and coordinated effort to educate the public and professionals about high blood pressure and its increased risk of heart attack and stroke. Much of the Program's success has been attributed to the many organizations and agencies at federal, state and local levels that are actively participating in the mammoth effort to control high blood pressure.

Despite the recent progress, however, problems remain that require additional attention. Men lag behind women in controlling hypertension, and control rates for black men do not approach those of their white counterparts. Since the prevalence rate of hypertension is greater among the black population, detecting and treating high blood pressure among this group assume even more importance.

One key to continued success in the national effort is the participation of health professionals in a number of settings, particularly in getting and keeping hypertensives under control. Health professionals at all levels can encourage adherence to therapy. They can:

- Improve patient education and counseling. Encouraging the development of appropriate patient behavior for blood pressure control is a critical task for all health professionals. Patients may need help in making a decision or personal commitment to control the disease, in forming new habits for regularly taking medication, in making lifestyle changes, in monitoring progress toward their goal, and in resolving problems related to therapy.
- Become familiar with current treatment recommendations. The Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure offers guidelines for detection and confirmation of blood pressure elevations, referral, patient evaluation (including laboratory workup), and stepped-care drug therapy. It also addresses additional issues including managing mild high blood pressure, patient education for therapy maintenance, nondrug treatment, drugs for use in stepped-care therapy, and managing the elderly and other special patient groups.
- Involve all types of health professionals. Successful control of high blood pressure requires patient access to a number of professionals participating in one or more steps within the control process. Yet barriers to interdisciplinary cooperation exist. Recent recommendations by a multidisciplinary panel that examined professional roles urge that those barriers be overcome in order to expand individual and community high blood pressure control services.

This May, National High Blood Pressure Month, is an appropriate time for us to examine our involvement in high blood pressure control and to determine how we might expand such efforts. Our efforts to encourage patient adherence can be multiplied by working with other groups that may have ongoing programs or resources to share. Some groups interested in cooperative efforts may be the American Red Cross, civic and fraternal organizations, community centers, fire and police departments, health departments, hospitals and clinics, industries, newspapers, professional societies, senior citizen and student groups, area health education centers, and extension agencies.

The 1984 High Blood Pressure Month kit is available to help health professionals work with patients and the public. The kit includes a program planning guide and educational materials that may be used in publications or in other ways. Copies of the Month kit and other information for professionals may be obtained from:

High Blood Pressure Month
High Blood Pressure Information Center
120/80 National Institutes of Health
Bethesda, MD 20205

DEAN'S MESSAGE

Research - a needed update

Research is vital to medicine as it is to most other scientific endeavors. Physicians acknowledge the critical nature of research and its contributions to patient care, the practice of medicine and improvement in the quality of life for all. Today, it is

necessary, perhaps critical, to restate and re-emphasize the importance of research in medicine. Though it might appear that this subject belongs in the "ivory tower" of the academic physician, the understanding and support of all practitioners of medicine is vital to the future of medical research.

Research is now endangered; endangered by well-meaning but misinformed individuals and their efforts. Congress has not only decreased research funding for NIH, it has also expanded control over medical research, particularly the use of animals. At the state level, in 1983, the Massachusetts Legislature enacted legislation to prohibit the use of shelter animals for research. The substitution of animals bred for research purposes increases cost significantly at the time that funding is diminishing.

The nature of controlled medical research precludes ill treatment of animals. No one involved in animal research can tolerate ill treatment. Researchers voluntarily subscribe to AALAC and USDA guidelines. These national groups inspect our research facilities and review our practices to assure compliance, while institutional committees oversee and review programs. Whenever feasible, alternatives are used including bacteria, cell and tissue culture, as well as computer simulation to test and retest theories.

Not all research can be completed without animal testing. Advances in modern medicine will continue to require animal subjects. Animal research has brought such diverse, but vital developments as artificial organs and organ transplant, open heart surgery, immunization, understanding of the immune mechanism, and the development of insulin. The efforts to produce an artificial heart could never have achieved success to the point of use in a human subject, were it not for extensive work with animal colonies.

Those who see themselves as protectors of animals have significantly increased their demonstrative efforts including marches, demonstrations and media events. Anti-vivisectionists are exerting political pressure on local governments in Florida to forbid the research use of shelter animals, who would otherwise be euthanized. These groups have significant national support.

Concern about the use of animals in research has been voiced for decades. We have often dismissed these concerns as minor annoyances. To ignore them today, however, would be tragic, injurious to our ability to train medical students, decrease the quality of medical practice, and tragic to the hope that thousands place in the promise of medical research.

The role of research in medical education is to provide for medical students the basis for critical thought processes necessary for the evaluation and incorporation of new information into medical practice. As this process carries over into the day to day practice of medicine, it makes better physicians of all practitioners.

The need for research, and in particular, animal research, is obvious and critically necessary for the continued development of medicine and the welfare of patients. Governmental bodies in Florida will face increased demands to curtail research projects which involve animals. The active support of the state's medical community is vital to insure that medical research continues in an appropriate fashion, under appropriate guidelines, with the goal of improving and enhancing the lives of all.

James A. Hallock, M.D.
Assistant Director, Medical Center
Deputy Dean, College of Medicine
University of South Florida

WORTH REPEATING

High touch medicine

Many varied and well-known external factors have profoundly altered the practice of medicine from the time when a solitary figure traveling in a horse and buggy dispensed more hope than remedy for cure. Social, legal, economic, governmental and technological influences have irrevocably transformed the physician from healer to health-care-provider. In these days a physician is as likely to be at one end of a "high-tech" device aiming laser medicine at a health care recipient as he is to be saving the life of a patient dying from bacterial meningitis.

As the mechanizing and bureaucratizing of medicine continues unabated, we wonder what has become of "high-touch," the reaching out by the compassionate, as well as competent, physician to the sick and often anxious patient? In other words, is the spirit of Hippocrates alive and well in the age of regulated and computerized health care? In short, where is the patient in the morass of modern medicine?

We have all heard patients complain about what they perceive as the uncaring attitudes of physicians. Patients want more of our time, more of our understanding, and more of our profession. And they want it for less. Many patients feel that they are being over-charged for the services they receive. Regardless of the accuracy of that impression, the oft-held perception of physician self-aggrandizement is certainly not responsible for the high costs of medical care. Yet, physicians on the front lines of medical care delivery are in large measure responsible for the satisfaction of their patients.

If doctors have been reduced to cogs in the system of the business of providing health care, then physicians should justifiably be able to turn to the experts in the business world for sound advice in the management of their practices.

A year-long best-selling book entitled "In Search of Excellence" (New York, Harper & Row, 1982) stresses that excellent companies are "brilliant on basics." One of those basics is the idea of learning from the people who purchase the products that the company makes. If a potato chip company can regularly listen to its customers in order to provide a better product, then so can the savvy physician whose solitary product is service — a very essential service.

Not only would careful listening to the consumer (patient) enable the provider (physician) to supply a better service (health care), but the inevitable by-products of such conscientious listening, namely, increased patient satisfaction and improved office efficiency would automatically accrue for an ultimately successful practice for us all. "High-touch" can and should complement "high-tech" in modern medical practice.

(Reprinted with permission from the *Hillsborough County Medical Association Bulletin*, January 1984.)

James A. Rush, M.D.
Tampa

Medicine, marketing, and public relations

Public relations and marketing have become as indigenous to American culture as the apple pie. Nothing sells in America nowadays without the stamp of Madison Avenue. Rare is a big outfit — whether it is a hospital, a school or a cub-scout organization — without a corps of public relations personnel to trumpet all its virtues to the world. Even politics has not escaped the proclivities of the PR and marketing professionals; the selling of the president every four years has become a classic example of the successful PR gambit to seduce the American public.

Medicine, that sturdy bastion of conservatism, is about to be charmed by the magic of the PR world. Across the country, physicians are being blitzed, McLuhan-like, to join the PR parade. Countless seminars are being held teaching physicians on how to be more effective messengers for the profession, how to dress properly, how to talk better, and how to work with the media more effectively. In the same vein, meetings as well as books and tapes are instructing increasing numbers of physicians on how to attract more patients, how to keep them, and what tactics to adopt to blunt the edge of competition. The effect of this PR blitzkrieg is all around us. More physicians are advertising their services, appearing on television to educate the public while talking business at the same time, and adopting strategies to keep their patients smiling and coming back. Even the AMA as well as many professional medical societies are promoting activities intended to create increased awareness among physicians of marketing and public relations as important adjuncts in their practices.

Why this sudden splurge by the medical profession to promote itself both professionally and economically? Physicians by tradition have been reticent about promoting themselves and plying their services. The medical code of ethics for many years forbade medical advertising of any kind; even when the Supreme Court legalized medical advertising after a prolonged struggle between the FTC and the AMA, very few physicians took advantage of the relaxed ethical guidelines. But a few things have happened since the Supreme Court decision to impel physicians to take a second look and to consider public relations and marketing as a saving grace for their profession.

For one thing, the image of the medical profession has been tarnished and it has become imperative for physicians to polish it up. In addition, the spectre of increasing competition and harsher economic realities have made many physicians nervous and have forced them to look on public relations and advertising agencies as a way to reclaim their traditional piece of the economic pie. Many commercial agencies in big cities now count among their clients several physicians, promoting them on TV, newspapers and magazines, and other media. As the economic crunch gets worse with the anticipated physician surplus, the number of those signing up is bound to increase. Lastly, the medical profession has reached a critical period in its history, engaged as it never has been before in a struggle for survival as an independent entity, and physicians have belatedly realized that they need everything they can muster to win public support on their side.

Many physicians of course have raised questions on whether it is proper for the medical profession to join ranks with the image-makers on Madison Avenue and whether it has not over-reacted to reports of its tarnished image and of increased competition. They point to annual surveys still showing physicians to be the most highly respected among professional groups in America, and to the fact that the so-called physician glut, whether it is here or still coming, will not adversely affect physicians' practices to any substantial degree. Furthermore, they feel that the aggressive pursuit of public relations and marketing

techniques carries with it an ugly stigma, cheapening instead of polishing the profession's image, and debasing the noble principles of the healing profession with cheap commercialization.

And there lies a dilemma. Caught between the voices of those who say we should and those who say we shouldn't, physicians should ponder the matter more seriously before embarking on an aggressive marketing and public relations campaign. Perhaps the middle ground, as in everything else, is the safest course. As a way to acquaint the public concerning health matters and issues, to educate patients, and to make Americans aware of what the medical profession is doing, public relations of this type is definitely needed. But as a way to promote economic interests, to neutralize competition, and to spruce up our image with cheap gimmicks, this is something that the medical profession can do away with. Sooner of later, the public will get the message.

(Reprinted with permission from *The Stethoscope*, bulletin of the Volusia County Medical Society, Winter 1983.)

R.G. Lacsamana, M.D.
Daytona Beach

Dilemma

The other day I saw through my mind's eye, a vision of medical practice, a helpless passenger in a horse drawn carriage, hurtling across the countryside at breakneck speed. The driver was leaning back with all his weight on the reins of the lead horse, screaming, "whoa-a-a." At the same time his sidekick was whipping the wheel horse into a frenzy. The incident that conjured this vision was the notice of my malpractice premium, $18,380. That amount would increase my practice overhead 66%.

I truly believe that medical practice is being propelled through time, by forces out of control, and we doctors are helpless to do anything about them. The helplessness, to a large degree, is caused by an unawareness of the hazard of our situation. Those propelling forces are many and varied but one strong one is the threat of litigation. That is the one I am addressing now and the one about which we should not be helpless.

The dilemma we are in is the same one that confronts all people when they are faced by an extortionist; pay protection and continue in business, refuse to pay and risk the consequences, or simply give up and quit. Well, I refuse to believe that malpractice suits are an inevitable accompaniment of our times and I won't accept paying tribute as a normal cost of doing business. Continuing to increase fees, to increase volume, or both, cannot indefinitely be acceptable.

I also refuse to adopt organized medicine's preoccupation with tort reform and its single-minded desire to "bust" plaintiffs attorneys. I grant that relief will only come with some reforms and "busting" of some attorneys but recent history informs me that success will require a different emphasis. I say that the Profession must look inward. The FMA had a powerful program last year with which it approached the Legislature. It was described as consisting of three approaches: one for the Legislature, one for the Judiciary, and one for the Public. It was felt that the three approaches might get the job done whereas a single thrust at the Legislature had little chance. As was demonstrated, however, that still wasn't enough. A fourth program will be required, a program directed at us doctors ourselves.

We really can't expect a very sympathetic ear from the legislators since so many of them are lawyers. That was the reason for the appeal to the public. It was hoped that pressure could be brought from that sector. It really shouldn't be a shock, however, to learn that we don't have much sympathy there either, especially if we have been listening to the message they have been trying to give us. They can accept the fact that we have troubles, even that we may face a crisis, but their collective reaction is, "too bad but they brought it on themselves." The public has been begging for evidence of personal concern, kindly consideration, communication, and advocacy. What they are seeing is the appearance of greed, arrogance, and ostentation. They read the published figures purported to be doctors' average incomes and can't help but compare them with their own, with teachers, ministers, and others. They see the bills presented to them and/or their insurance companies and they resent it when they are treated in a cavalier fashion by someone within the profession. No, at this time we don't have their sympathy. We can't really count on their support and without it I see no lessening of the crisis.

We have adequate guidelines in the AMA "Principles of Medical Ethics." Individual doctors have been permitted to behave, however, in a manner that alienates society, and unfortunately, while they are not numerous they are very visible. Slick, well financed legislative programs will never be enough. A grass roots movement must accompany the other efforts and it must be sincere. Society is asking us to care for them. They will perceive this when they see unharried, controlled practices and the appearance of humility. They will be with us when they are convinced that service is the major motivating force of the Profession. A trusting patient who believes

the doctor was fair and did the best he or she could, regardless of result is just not likely to sue. When that relationship is restored, legislative relief is possible.

(Reprinted with permission from the *Newsletter* of the Capital Medical Society, February 1984.)

James K. Conn, M.D.
Tallahassee

CORRESPONDENCE

Dear Editor: I congratulate the Florida Medical Association on its fight against alcohol and drug abuse, and on the fine special edition you published on the topic in April.

Substance abuse is one of this nation's major health problems. More than 15 million Americans suffer from addictive diseases. If we add the other victims — suffering family members, friends and employers — the number jumps to 75 million. So much of the physical and emotional trauma connected with addictive diseases could be prevented through public education. By informing the public of the disease concept of addiction, we can help to remove some of the stigma of admitting an alcohol or drug problem and, hopefully, more people will "come out of the closet" and seek treatment.

As physicians, we, unfortunately, have the opportunity to view the effects of alcohol and drug abuse more than the average individual. We must do everything in our power to make the public aware of the problem and of the possible solutions. I urge every member of the Florida Medical Association to play an active role in the fight against alcohol and drug abuse.

David G. Pinosky, M.D.
Medical Director
Highland Park General Hospital
Miami

CORRECTION

Correction on President's Page

The following sentence on page 209, second paragraph, of the April issue (Vol. 71, No.4) should have read, "The constitutional revision proposal for the November ballot has been prepared and will be distributed shortly to physicians' offices, the Florida Medical Association Auxiliary and citizens across the state."

BOOK REVIEWS

Book Review Editor — **F. Norman Vickers, M.D.**

The Crohn's disease ulcerative colitis fact book

Edited by P.A. Banks, M.D., D.H. Present, M.D., and P. Steiner, M.P.H. Price $14.95. Charles Scribner's Sons, New York 1983.

Aimed at patients with inflammatory bowel disease, this book details the nature of the conditions and their treatment. The need for such a book is clear: little information has been published for the patient population distressed with these chronic illnesses. However, this effort struggles to achieve authenticity only to miss the mark. There are three editors and 23 contributors to a text of 158 pages. This produces a book by committee, uneven and somewhat confusing. Ulcerative colitis and Crohn's disease are discussed together. The patient who has ulcerative colitis does not want to read about Crohn's and visa versa. The book attempts to follow the format of medical literature. It uses technical words such as dysplasia and granuloma. Wouldn't "flare-up" be a better term instead of exacerbation? The result is a dilute medical text rather than a book for patients.

C.C.

Practical dermatology

By I.D. Sneddon and R.E. Church, 244 Pages. Price $17.50. Edward Arnold Publishers, Ltd., (London), 1983.

This well written and concise book is based on a series of lectures given at the University of Sheffield. Unfortunately, the practical part of the title refers to specific drugs and other therapies well known to the British Health Service, but obscure to an American audience. Aside from terminologic differences, a number of treatment suggestions (i.e., x-irradiation for herpes simplex) would not be acceptable this side of the Atlantic. Even its bargain price would, therefore, not make it a good value for the generalist.

K.J.K.

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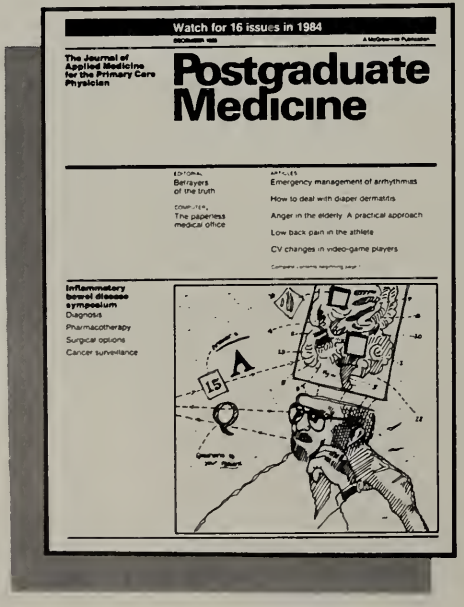
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Auxiliary Liaison Editor — **Mrs. L. G. (Mae) White**

Politics . . . like it or not it's ours!

If life requires humor, politics must generate a guffaw. It is at once serious and absurd. One moment intellectually invigorating and the next insufferably stupid. It is a triumph and a disaster. It is human beings being all that embodies their finest and bleakest attempts at sane and just governance. Call it what you will, blessing or curse, but its ours and its here to stay.

Involvement in the political process by medical families has increased dramatically over the last few years. Poor medical legislation. the malpractice crisis, and governmental encroachment in health care delivery have encouraged many to get involved. Participation in the political process is a necessity in a democratic society. If we wish to affect change, social or political, we must be willing to actively participate. Someone else cannot do for us the way we can do for ourselves. Politics is not magic, it is not reverent, nor is it to be revered. It is made by people just like you and me, for people like you and me. We each have the right for input, and the only flaw in the system is when we refuse to accept the responsibility for having that input.

In an effort to encourage involvement, it is first necessary to encourage understanding. For this reason, the Auxiliary is making political education a top priority. Legislative updates have been made more readable. Each month "Legislation in a Nutshell" is sent to every Auxiliary in the state, with its primary purpose being to familiarize Auxilians with medically related legislation. Often it is the Auxilian who takes legislative information back to his or her medical family. It has been found that a discussion at an Auxiliary meeting can also precipitate discussion at home, thus giving the physician another opportunity to be updated on pending medical legislation.

The Auxiliary's LEGS Alert program continues to be successful. The concept is a simple but efficient one. However, it is only as good and effective as the participants are willing to make it. When you are contacted with a request for help on a particular legislative issue, please do your part to make the system work productively.

I have heard some say that politics is beneath them. Such a sentiment shows a great deal of ignorance about the way our system functions. At best such a declaration reflects a short sighted interpretation of what it means to compromise and to tolerate conflicting opinions and approaches; the worst is that it is an uninspired explanation for "copping out". Politics by definition is the art or science of government. It is not perfect; but should we expect it to be? Politics by nature requires pragmatism, that pragmatism was assured when it was decided to make our form of government "of the people, by the people, for the people". It can only be as great as you and I are willing to make it. Together the potential for greatness is boundless.

Carolyn C. Spore
State Legislative Chairman
FMA Auxiliary

Roche salutes the history of Florida medicine

THE ICE MAN OF APALACHICOLA



Dr. John Gorrie

Medical history is replete with statistics regarding deaths from fever, and before the middle of the 19th century, little could be done to aid the afflicted. Yellow fever, smallpox, typhoid and scarlet fever were scourges that came in epidemics and caused rapid elevation of body temperature from which, all too often, the victim died.

Even for sunstroke patients, lowering body temperature—when attempted at all—was rough and crude treatment consisting of dunking the victim, often fully clothed, into cold water.[1]

Patented invention

It was, therefore, a significant medical development when, on May 6, 1851, U.S. patent No. 8080 was granted to Dr. John Gorrie of Apalachicola for his mechanical refrigeration technique that perfected the process for making artificial ice.[2]

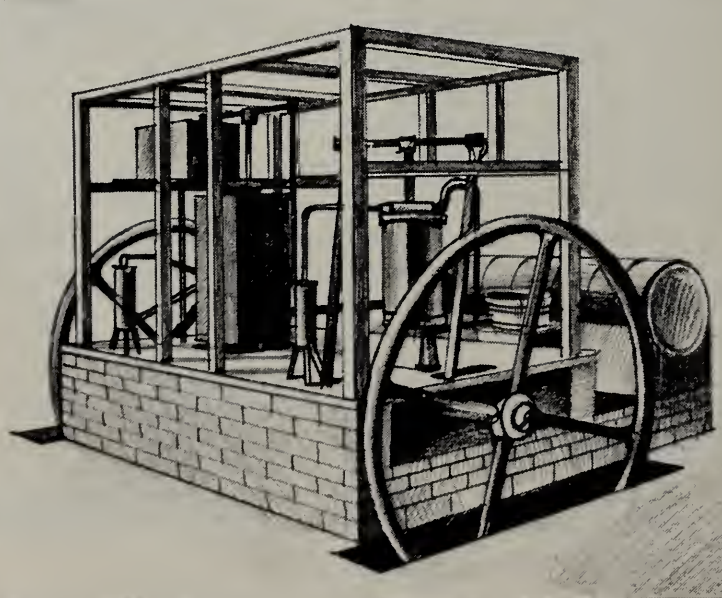
Dr. Gorrie installed his artificial ice machine in the United States Marine Hospital in Apalachicola;[2] there it came to the attention of other Florida physicians, who began to explore ways of using the ice-making process in preventing and treating yellow fever.[3]

Now a necessity

Today its medical applications are myriad—medications are kept fresh, foods are kept chilled, germs are kept under control, patients are kept comfortable and, often, treatments include applications of ice packs. All these conveniences and treatments—and more—are direct descendants from the historic invention of Dr. John Gorrie.

References: **1.** Headquarters: The hospital, chap. 7, in Lee RV, Eimerl S *et al: The Physician.* New York, Life Science Library, Time Inc., 1967, p. 149. **2.** Kane JN: *Famous First Facts,* 3rd ed.; New York, The H. W. Wilson Co., 1964, p. 518. **3.** Day SM: *J. Fla. Med. Assoc. 69*:719, 1982.





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PRESIDENT'S
MEMO:
FLORIDA MEDICAL ASSOCIATION, INC.
760 RIVERSIDE AVENUE / BOX 2411 / JACKSONVILLE, FLORIDA 32203 / (904) 356-1571

C-3
June 13, 1984

RE: *Reason '84*
Constitutional Initiative Campaign
Signature Petition Drive

Dear Colleague:

The signature petition phase of our constitutional initiative campaign, *Reason '84,* is now entering the final four (4) weeks.

The response from the FMA membership has been encouraging and I urge each of you to actively continue your support to ensure our success.

By July 15, we must have collected approximately 500,000 signatures in order to have the necessary 300,000 validated signatures required to have our proposed amendment placed on the November 1984 General Election Ballot. All of the signature petitions must be validated by August 7, 1984.

During the critical weeks remaining, we need your help to expedite the signature collection process. If you practice in an office setting, please make every effort to personally discuss the campaign with your patients; but if you do not have time to do this, designate someone from your staff to ask each patient and visitor to sign a petition.

The Reason '84 Campaign packet that you received contained valuable information to help you; but if you need additional materials and/or information, please call the Reason '84 Campaign Headquarters at (904) 355-3252. An attractive display complete with petitions and brochures is available for your office.

Remember, any registered voter in Florida can sign a petition. Please make a special effort to have the voter's correct county on the signature petition. It is not necessary to list the voter's precinct or congressional district. This information will be added by the Campaign Office staff.

It is important to mail the completed petitions to the Campaign Office as soon as possible.

Reason '84
P.O. Drawer 2640
Jacksonville, Florida 32203

The County Supervisors of Elections have requested that we turn in signatures each week and not wait until the last minute.

I am confident that with your help, our amendment to bring about tort reform in Florida will be on the General Election Ballot this November and will ultimately be approved by the voters.

Sincerely,

Frank C. Coleman, M.D.
President

PRESIDENT'S PAGE

A call for unity and participation

One Profession — One Association — One Future



John Naisbitt, in his book, *MEGATRENDS*, says that change occurs when there is a confluence of both changing values and economic necessity, not before.

We as physicians certainly are in a time of great change, a change that is so dramatic and so sudden that it has dazzled many of us. It is clear that changing values and economic necessity are primarily responsible for this change. The public does not look upon doctors as it did a generation ago, and both business and government are rebelling against the high cost of health care. The question now is whether the cost of health care should be controlled by the competitive approach or by the regulatory approach. Unfortunately, with cost containment as the watchword, little is being said about the impact of cost containment on the quality of care.

Prospective payment for hospitals for Medicare patients using DRGs is now a reality and this same concept may well be extended to physicians. Our legislature has been debating whether to give the Hospital Cost Containment Board the authority to regulate hospital rates for private patients. Physicians are being pressured to accept assignment on both Medicare and private patients. HMOs and PPOs are springing up like weeds.

There is increasing discussion about rationing of care and the ethical problems involved in care of the terminally ill. One out of every three Florida physicians will have a malpractice claim filed against him this year.

In some specialties, we have an oversupply of physicians. This excess of physicians leads to intense competition for patients and makes participation very attractive in some of the non-fee-for-service delivery systems.

I believe that we should take the positive view and remember that our obligation as physicians, as it always has been, is to provide quality medical care regardless of the changing times. This is a sacred trust and must be defended with all of our strength.

The House of Medicine must make whatever adjustments should be made to defend this trust. The roof covering the House of Medicine must be broad enough for every physician to participate in the decision-making of the Florida Medical Association and in the implementation of these decisions.

I have appointed a Programs and Priorities Committee to review our activities and make recommendations to the Board of Governors with respect to them. I have appointed a Committee on Health Manpower to deal with the problems being encountered with the multiplicity of allied health groups in their efforts to obtain independent status. I have appointed a Bylaws Committee to look carefully over our operating rules.

As a result of recent actions by the FMA House of Delegates, a new Council on Hospital Medical Staffs has been established with one vote in the House.

This is a start toward implementing the principle that people whose lives are affected by a decision must be part of the process of arriving at that decision.

The theme of my administration as President during the coming year will be:

One Profession - One Association - One Future

One Profession: No matter what specialty we are, no matter what our mode of practice, we are all

physicians first. We must work to further the best interests of that profession, knowing that none of us can succeed unless the profession succeeds.

One Association: The state Association, in cooperation with all of the county medical societies and specialty organizations, must have unity and represent all physicians. It must have programs, projects, policies and a philosophy that meet the needs and further the goals of all physicians, regardless of their individual attributes and circumstances.

One Future: What happens to any of us happens to all of us. Some physicians cannot succeed while others fail. We all succeed together as physicians; or we all fail. Whatever differences exist, our response to problems of the future — legislative, economic, professional, scientific — must be focused toward the needs of all.

Frank C. Coleman MD

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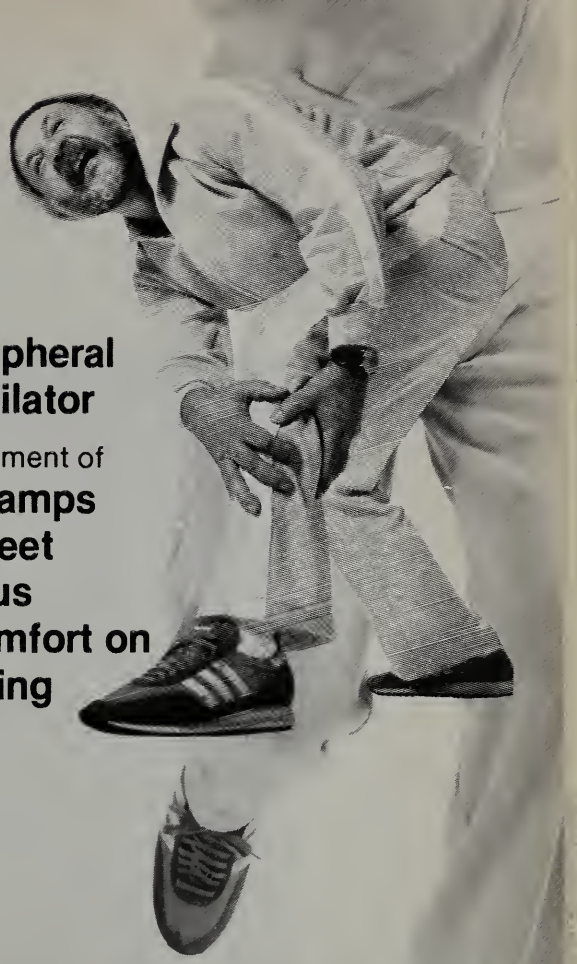
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Frank C. Coleman, M.D.
108th President
Florida Medical Association

EDITORIAL

Frank C. Coleman, M.D.

Frank C. Coleman, M.D., of Tampa became the 108th President of the Florida Medical Association when he took office on May 6, 1984. In assuming this important position at a time when some of the greatest challenges ever to confront the FMA loom on the horizon, Dr. Coleman brings vast experience and ability which will serve the FMA exceedingly well in the year ahead.

As the new President of the FMA, Dr. Coleman may be appropriately classified as a Renaissance Man of organized medicine with a wealth of skill in the practice of medicine, in medical education and in the socioeconomic, political and legislative aspects of medical practice.

Dr. Coleman is a native of Jackson, Mississippi. After attending public schools there, he received his undergraduate degree at Mississippi College. He was graduated from Tulane University School of Medicine. He had his internship and residency training in pathology at Touro Infirmary. He has been certified by the American Board of Pathology in Clinical Pathology, Anatomic Pathology, Forensic Pathology and Blood Banking.

Dr. Coleman began the practice of pathology in Des Moines, Iowa, where he was director of the Department of Pathology at Mercy Hospital and served as staff pathologist for several other hospitals in the area. After nearly 20 years in Iowa, he moved to Tampa, Florida, in 1964 and became the managing partner of the Patterson-Coleman Laboratories, which he developed into one of the largest independent medical laboratories in the southeast. He has been a staff pathologist and consultant to many hospitals in the Tampa area.

Dr. Coleman became interested in medical education early in his career and developed a residency program in pathology while he was in Iowa. He has also established programs for training medical technologists both in Iowa and Florida. Appointments as Clinical Professor of Pathology at the State University of Iowa College of Medicine and at the University of South Florida College of Medicine are indicative of his long time commitment to medical education. He has many other widely varied experiences in medical education. He was chairman of the medical school committee of the Tampa Chamber of Commerce, a panel which played a key role in the establishment of the University of South Florida College of Medicine. He has been a member of the Florida Community Hospital Education Council since 1971, with a term as chairman. In an important activity related to education, he has served as a trustee and as president of the American Board of Pathology. He was a member of the Iowa State Board of Medical Examiners and was elected to be its secretary.

Dr. Coleman's activities in political and legislative affairs began with service on the legislative committee of the Iowa State Medical Society. His work in legislative affairs led to his selection to be a member of the Council on Legislative Activities of the American Medical Association with a term as its chairman. While he was on the AMA Council on Legislative Activities, he identified the need for a separate political arm of organized medicine and was instrumental in organizing the American Medical Political Action Committee which he served as an early chairman. He has been actively involved in the campaigns of candidates for political office from the

local level to the presidency of the United States. These experiences have provided him with unusual knowledge and skills to deal with the Congress and the federal bureaucracy.

Dr. Coleman's work as a member of the board, as treasurer, and later as president of the Florida Medical Political Action Committee are well known to Floridians. He has been a member and chairman of the Council on Legislation of the Florida Medical Association. His experiences in legislative affairs have given him excellent qualifications to represent the FMA to members of the Florida Legislature and to the executive branch of the Florida state government.

Dr. Coleman has gained much experience in health manpower issues through many of the activities previously mentioned. An additional factor of importance in his background was his service as a member and chairman of the Council on Health Manpower of the American Medical Association. Dr. Coleman is one of very few individuals who has been chairman of more than one AMA council with chairmanships of the Councils on Health Manpower and Legislative Activities. He has also been a member of the subcommittee on Professional, Scientific and Technical Manpower of the National Manpower Advisory Committee to the U.S. Department of Labor. He had a term as chairman of the Council on Health Manpower of the Florida Regional Medical Program.

Dr. Coleman's knowledge of the socioeconomic arena was enhanced by membership on the board of directors of both Iowa Medical Service (Blue Shield) and Blue Shield of Florida. He had a term as chairman of the Iowa organization. He was a member of the Committee on Health Services Industry for the Wage and Price Board under the Economic Stabilization Act in 1972. He was on the Professional Standards Review Organization (PSRO) Advisory Committee of the American Medical Association.

In organized medicine, Dr. Coleman's talents have long been highly regarded. He was a delegate to the American Medical Association from Iowa and has been an AMA alternate delegate from Florida for several years. The Hillsborough County Medical Association elected him president after he had served on virtually all of the important committees of that organization. He has had many important committee assignments in the Florida Society of Pathologists, and served as president of the Florida Association of Blood Banks. At the national level he was elected as president of the College of American Pathologists and later to the presidency of the American Association of Blood Banks with numerous important committee assignments in both organizations.

Dr. Coleman has not confined his activities to organized medicine but has participated in the Chamber of Commerce, both in Des Moines and in Tampa. He is a member of the Rotary Club of Tampa. He has been a director and president of the Gulf Coast Symphony. He served as a member of a special committee on the nation's health care needs of the Chamber of Commerce of the United States. He was a member of the executive committee of the Tampa World Trade Council. Recently he has been actively engaged in promoting the concept of business-medicine coalitions in an effort to help stem the tide of rising health care costs.

Dr. Coleman has been the recipient of numerous awards from medical organizations. The Iowa State Medical Society presented him the Award of Merit. He was given the Distinguished Service Award by the American Society of Clinical Pathologists and the College of American Pathologists. The Greater Tampa Chamber of Commerce honored him with the President's Award. A Certificate of Appreciation was awarded him by the American Medical Association.

The preceding paragraphs only partially recount some of Dr. Coleman's more important activities, achievements and honors. A mere listing of these items does not do justice to the man. Dr. Coleman is regarded by his peers as a warm and caring human being who is always ready to give full attention and support to his colleagues. Virtually all of his activities have served to help the practice of medicine in general with very little personal reward for him. People in all walks of life who have been fortunate enough to work with him have been overwhelmed by his integrity and sense of fair play. Individuals who have participated with him in any of his multiple activities over the years readily attest to the depth and constancy of his inner being. He has had a profound effect on the professional career of many individuals who uniformly indicate their pride at being his friend and colleague.

Dr. Coleman is married to the former Ruth Yvonne Ellzey of Jackson, Mississippi. The Colemans have four fine children — Nancy, Stephen, John and Jeanne. Incidentally, Mrs. Coleman is a past president of the Hillsborough County Medical Association Auxiliary and the Florida Medical Association Auxiliary.

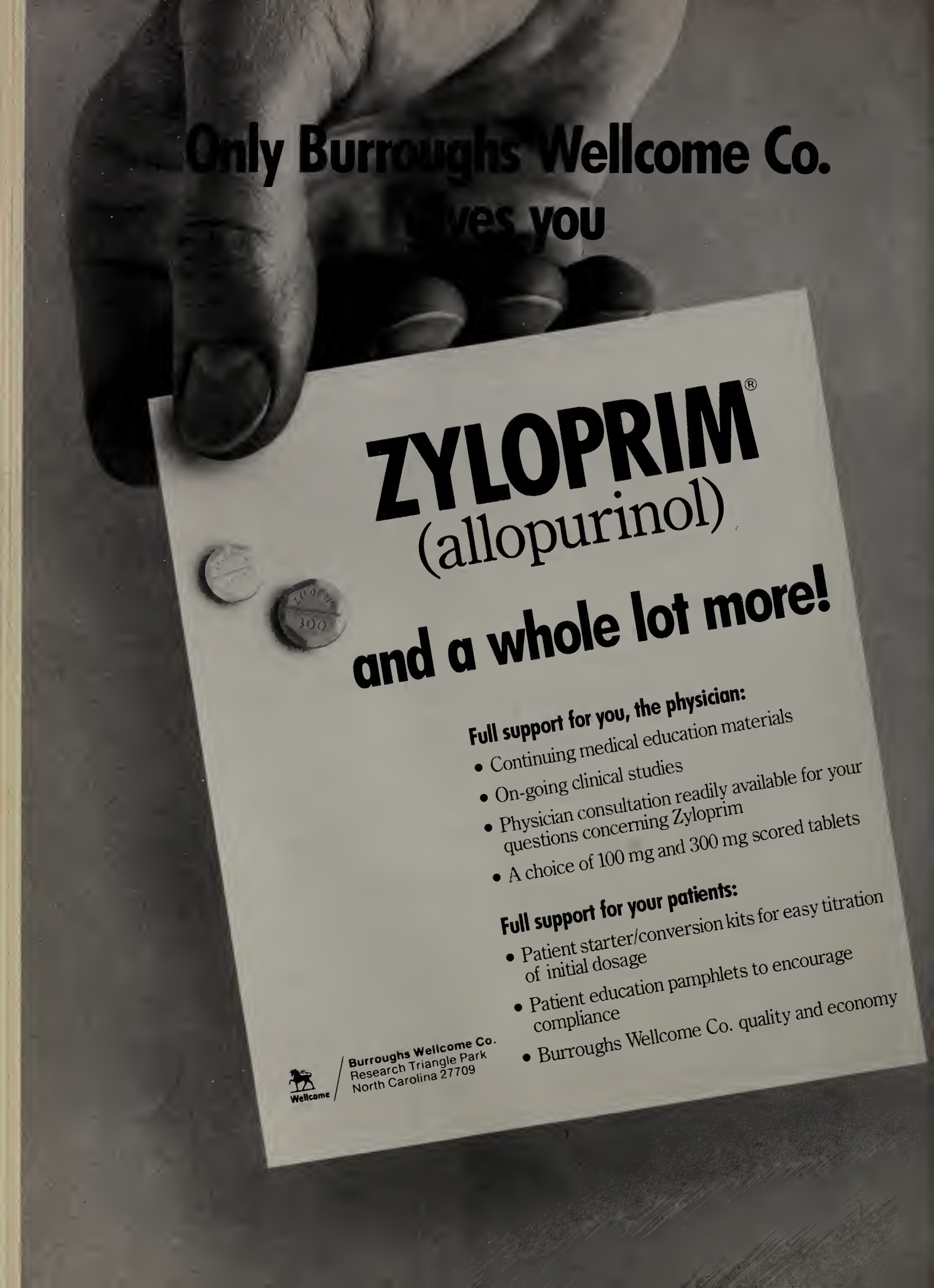
At a time when medicine faces challenges from politicians who are trying to make medicine the whipping boy for the problems of health care costs, when multiple paramedical groups want to join in the practice of medicine without a medical degree, when the problems of financing professional liability insurance threaten the very structure of medicine, when governmental bodies at all levels are threatening the financial integrity and security of physicians in the practice of medicine, when legislative bodies are involving themselves in the specifics of medical prescribing and treatment, when financial crises loom in the very near future for our hospitals and our medical educational institutions, when, in

short, virtually everything and everyone is attacking the honored practice of medicine, the members of the Florida Medical Association could not have chosen a more qualified leader to guide them through the many mine fields which lie ahead in the coming year.

By his background as a highly qualified practicing pathologist, as an interested and able medical educator, as an experienced administrator, as a knowledgeable representative in the socioeconomic field, as a skillful negotiator in political and legislative affairs, and as a fine and respected citizen, Dr. Coleman will bring talents to the Florida Medical Association which bode well for the future. We wish him luck and we know that all members of the FMA stand ready to be supportive of our superbly qualified leader, Frank C. Coleman, M.D., in his year as the 108th President of the Florida Medical Association.

Sanford A. Mullen, M.D.
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Management of the patient alloimmunized to platelets

Peter A. Tomasulo, M.D.; Donald Doddridge, and Alice W. Reynolds

ABSTRACT: The American Cancer Society, Florida Division, has partially funded development of a statewide pool of HLA-typed platelet donors. With the Florida Association of Blood Banks, blood centers in Gainesville, Orlando, St. Petersburg and Miami have been selected to type large numbers of volunteer pheresis donors and provide HLA-matched platelets to any Florida patient in need.

The resource is available to any Florida patient who has become refractory to platelets whether in a major university teaching hospital or a small community hospital. Physicians treating patients who no longer respond to platelet transfusion or those who may become refractory are encouraged to contact one of the four participating centers. The best matched platelet donor will be recruited for specific patient needs and if necessary the platelets will be shipped from the donor's location to the patient. The system should reduce cost and increase the quality of medical care.

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Patients receiving frequent blood and component transfusions may become refractory to random donor platelets. The destruction of transfused platelets is probably due to antibodies (mainly HLA antigens) stimulated by blood transfusions or pregnancy. The incidence of refractoriness may vary from less than 50% to 100% and there is controversy concerning the existence of a direct dose relationship between the number of previous platelet transfusions and the development of alloimmunization.[1-4] Nevertheless, it is generally agreed that alloimmunization represents an important long-term complication of platelet transfusion.[4] The management of alloimmunized patients is one of the most difficult and frustrating problems facing the clinician and indeed they may be the only ones with malignant disease who ever succumb to hemorrhage.[3,4] The purpose of this communication is to describe a statewide cooperative program to treat Florida's patients refractory to random donor platelets.

The Florida system • In 1982, at the initiative of faculty members of the University of Florida College of Medicine, the American Cancer Society, Florida Division, funded a program to establish a statewide pool of HLA-typed volunteer donors to treat patients refractory to platelet transfusions. The program was established in collaboration with the Florida Association of Blood Banks (FABB). The recipients of the ACS grant were the South Florida Blood Service in Miami, Central Florida Blood Bank in Orlando, Community Blood Bank in St. Petersburg, and the Civitan Regional Blood Center/University of Florida in Gainesville. The charge was to develop a cooperative system of HLA-typed donor pools to procure matched platelets for refractory patients anywhere in Florida. The ACS and the FABB sought to have

the blood centers type large number of donors in strategic locations thereby preventing the duplication of unnecessary expensive resources and providing the most sophisticated form of health care for all Florida's patients. The first year's goals included the typing of 2,000 new donors, establishment of quality control measures for the centers and development of communication systems to faciliate the sharing of matched platelets. The goals were met. Subsequently in September 1983 new grants were awarded by the ACS to each of the four centers to continue recruiting and typing potential platelet donors and to further implement the statewide program.

Currently more than 5,000 HLA-typed donors are available. Platelet concentrates are drawn in one city and shipped to another as a routine part of this program. Records indicate that the pool is too small to meet the needs of all Florida's patients (HLA-typed donor pools outside Florida are still often accessed) but good progress is being made and many refractory patients have been maintained with the help of the statewide donor pool.

Accessing the system:

Definition of Refractoriness • Any physician treating a patient who is refractory to random donor platelets may obtain HLA-matched platelets from one of the four centers. Once the physician suspects that the patient is refractory, he should confirm his impressions by obtaining platelet counts immediately before a transfusion of 10 to 15 units of random donor platelets and one and 24 hours following. Because recipients differ in size, it is helpful to express increments in a standardized fashion such as the "Corrected Count Increment" (CCI).[3]

$$CCI = \frac{(\text{postcount} - \text{precount}) \times \text{body surface area } (m^2)}{\#\text{ of plts transfused}}$$

Using this formula one would expect an increment of approximately 20,000/ul one hour after transfusion of one unit (5.5×10^{10} platelets) per ten kilograms to a nonrefractory patient. If the corrected count increment is less than 10,000 at one hour or less than 7,500 at 24 hours refractoriness is likely.[5,6]

Alloimmunization is also associated with the presence of complement fixing lymphocytotoxic antibodies. Approximately 90% of all patients believed to be alloimmunized clinically have been shown to have lymphocytotoxic antibodies.[3] The presence of antibodies alone does not make the diagnosis but in conjunction with poor platelet responses is very helpful in estimating whether a patient is refractory.

The diagnosis of refractoriness is complicated by other clinical factors which decrease the response to platelets such as severe infection, disseminated intravascular coagulation, fever, and splenomegaly. These factors should be considered when analyzing platelet transfusion responses. Many patients with severe malignant disease are both immunized to platelets (refractory) and have other causes of poor platelet response (severe infection). Sometimes these patients can be helped by providing HLA-matched platelets.

Arranging for HLA-matched platelets • In some circumstances, it is prudent to HLA-type a patient before refractoriness develops if prolonged aplasia and many transfusions are anticipated. Once refractoriness is documented, the physician should contact the nearest FABB member or transfusion service and request HLA-matched platelets through the system. If this is not convenient any one of the four centers can be contacted directly and they will involve the local FABB member.

Because selection of an HLA-typed donor requires detailed knowledge of previous transfusion responses, it is necessary to supply the center with the clinical and laboratory results of previous platelet transfusions and of each HLA-matched platelet transfusion. It also is necessary to identify other causes of poor response in order that the center can select the best potential donor for each subsequent transfusion.

Individuals to contact at each of the centers are: in Miami, Susan Tabler, RN, South Florida Blood Service, (305) 326-8888 (working hours), (305) 325-0154 (nights and weekends); in St. Petersburg, Linda Smith, RN, (813) 327-0168 (working hours), (813) 327-5663 (nights and weekends); in Orlando, Nancy Peterson, MT(ASCP)SBB, (305) 849-6100 (working hours), (305) 423-4811 (nights and weekends); and in Gainesville, Tammy Tackett, MT(ASCP), (904) 377-6905 (working hours), (904) 376-3250 Pager 2112 (nights and weekends).

Summary • The statewide system is advantageous because all four centers are committed to helping patients throughout Florida. They are prepared to draw donors locally and ship platelets wherever needed. Frequent planning meetings have resulted in development of prompt and efficient shipping schedules and a communication network that identifies patient needs and reports these to appropriate centers. HLA-matched platelets are available to all Florida patients whether cared for in a major tertiary care medical center or in their own community hospital. The controlled investment in this system will provide a fully utilized resource which will meet Florida'a growing needs with minimal duplication of resources and unnecessary expenditure.

The system should be of major help to physicians caring for patients with malignant disease. The physician who has accessed the system need not be

concerned about recruiting donors of the appropriate HLA-type, providing pheresis equipment, providing for testing the product and shipment to the patient. These functions are performed by the system once the patient's need is identified and documented. The system can be accessed seven days each week.

The American Cancer Society, Florida Division, and the Florida Association of Blood Banks are involved in many programs to facilitate patient care. Florida Medical Association members are encouraged to learn more about them by contacting the local FABB blood bank or the American Cancer Society, Florida Division, in Tampa.

References

1. Dutcher, J.P.; Schiffer, C.A.; Aisner, J., and Wernik, P.H.: Alloimmunization Following Platelet Transfusion: Absence of Dose Response Relationship, Blood 57:395-398, 1981.
2. Dutcher, J.P.; Schiffer, C.A.; Aisner, J., and Wernik, P.H.: Long Term Follow-up of Patients with Leukemia Receiving Platelet Transfusions: Identification of Large Group of Patients Who Did Not Become Alloimmunized, Blood 58:1007-1001, 1981.
3. Menitove, J.E.: Platelet Transfusion for Alloimmunized Patients, Clinics in Oncology 2:587-609, 1983.
4. Tomasulo, P.A.: Management of Alloimmunized Patient with HLA-Matched Platelets. In Platelet Physiology and Transfusion, Schiffer, C.A., ed., American Association of Blood Banks (Washington DC) 1978, pp 69-82.
5. Daly, P.A.; Schiffer, C.A.; Aisner, J., and Wernik, P.H.: Platelet Transfusion Therapy, One Hour Post Transfusion Increments Are Valuable in Predicting Need for HLA-Matched Preparations, JAMA 243:435-438, 1980.
6. Hogge, D.E., Dutcher, J.P.; Aisner, J., and Schiffer, C.A.: Lymphocytotoxic Antibody Is a Predictor of Response to Random Donor Platelet Transfusion, Am.J.Hemato. 14:363-370, 1983.
7. Menitove, J.E. and Aster, R.H.: Transfusion of Platelets and Plasma Products, Clinics in Hematology 12:239-266, 1983.

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Intraoperative electrophysiology in treatment of peripheral nerve injuries

Barry J. Kaplan, M.D.; Dietrich Gravenstein, and William A. Friedman, M.D.

ABSTRACT: Peripheral trauma can result in formation of a neuroma-in-continuity. Axonal regeneration across the lesion is variable. The definitive method of assessing regeneration is intraoperative nerve action potential (NAP) recording. Conduction across a neuroma-in-continuity is indicative of regeneration and no further therapy is necessary. If, however electrical activity cannot be recorded, then resection with primary nerve suture or nerve grafting is undertaken to create a new pathway for regeneration.

Peripheral nerve trauma may result in nerve division or lesions-in-continuity. Injection injuries, stretch, contusion, fractures, and gunshot wounds tend to cause neuromas-in-continuity.[1] External inspection will not reliably predict whether regeneration will occur through such a lesion leading to a surgical dilemma: should the area of injury be resected and the nerve sutured or should further time be allowed for axonal regrowth and muscle reinnervation to spontaneously occur? The advent of intraoperative nerve action potential recording has largely obviated this difficulty.[2] In the following paper the details of this valuable technique are presented, along with illustrative case reports.

Methods: Nerve action potential technique • Nerve action potentials (NAPs) are produced by stimulating one point on the nerve and recording the propagated action potentials at another site (Fig. 1). Utilizing sterile stainless steel bipolar electrodes, stimuli of .01 msec duration and 50-90V intensity are applied to the nerve at a rate of 5Hz (Grass S11 Stimulator). A stimulus isolation unit (Grass SIU8T Stimulus Isolation Unit) and very low stimulus durations are utilized to reduce the size of the stimulus artifact. An identical electrode is used for recording purposes. The signal is amplified approximately 10,000X with filters set at .1Hz and 30kHz (Grass Model 12 Neurodata Acquisition System). Though NAPs can sometimes be visualized on single sweep recordings, the use of computerized signal averaging greatly enhances the quality of the recording (Tracor Northern NS575-A Digital Signal Analyser).

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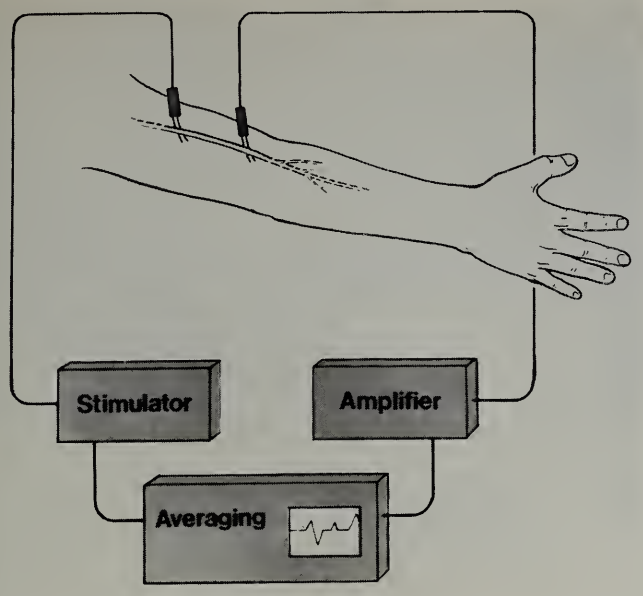


Fig. 1.—A schematic diagram illustrates the system employed in nerve action potential recording. The nerve stimulator also triggers the sweep of the averaging computer. The amplified biological signal is extracted from the background noise.

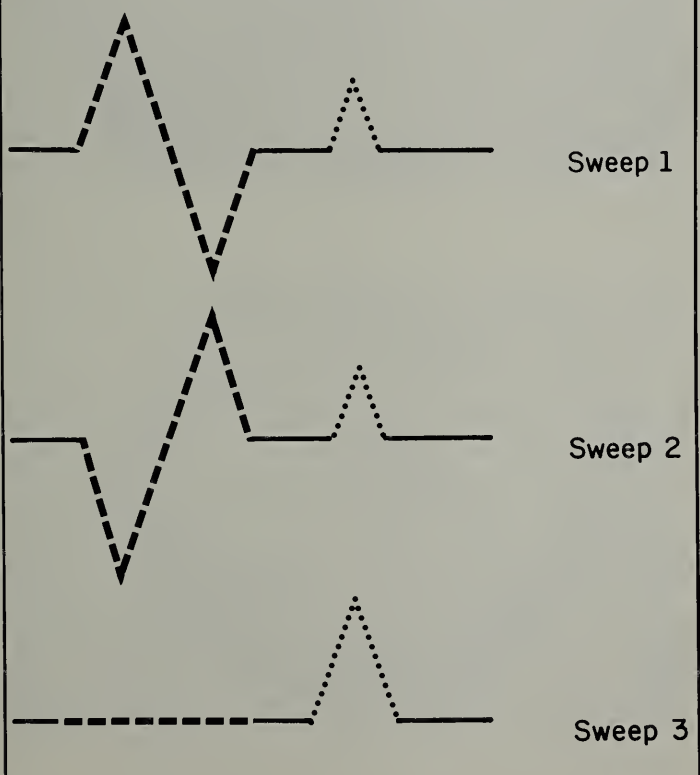


Fig. 2.—The large signals in sweeps 1 and 2 (dashed lines) represent idealized background noise. Since noise is random it tends to add to zero over the course of multiple sweeps. The smaller biological signals (dotted lines) add in one direction. Signal averaging, therefore, results in enhancement of small signals which otherwise would be obscured by background noise (sweep 3).

The averaging computer is triggered by the nerve stimulator. The preamplified input is, therefore, time-locked to the stimulus. All background electrical activity tends to average to zero over the course of multiple sweeps, resulting in enhancement of the biological signal (in this case, the NAP, Fig. 2). The resulting trace is visualized on an oscilloscope and recorded on magnetic tape. Later, an X-Y plotter is utilized to produce a hard copy of this data for the patient's records.

During the intraoperative recording of NAPS, both the stimulating and recording electrodes should first be placed proximal to the identified lesion. As this section of nerve is presumably normal, an NAP should be easily recorded, verifying that the equipment is functioning properly. One electrode is then moved just distal to the lesion and the procedure repeated. The presence of a NAP in this situation indicates that axons have grown across the area of pathology.

Case Reports ● **Case 1.**—This 31-year-old white male sustained an avulsion laceration of the superolateral aspect of his left arm just above the elbow. He noted the immediate loss of ability to extend his wrist and fingers. Physical examination revealed necrotic musculature and foreign debris at the base of the wound. Pulses were intact. Neurological examination demonstrated plegia of the left brachioradialis, extensor carpi radialis and ulnaris, extensor digitorum communis, abductor pollicis longus, and extensor pollicis longus. Triceps strength was normal. Deep tendon reflexes were 2+ bilaterally. Pinprick hypalgesia was present over the dorsolateral aspect of the left hand. Radiographs failed to reveal a fracture. The wound was copiously irrigated and closed in one layer.

Examination seven weeks later was again consistent with a complete distal radial nerve palsy. An EMG demonstrated denervation of all distal radial nerve musculature. The clinical examination in conjunction with the EMG findings suggested that surgical exploration was indicated. At the time of surgery, the radial nerve was exposed between the brachioradialis and biceps muscles. A neuroma-in-continuity (Fig. 3) was encountered at the level of the avulsion laceration measuring 3 cm in length.

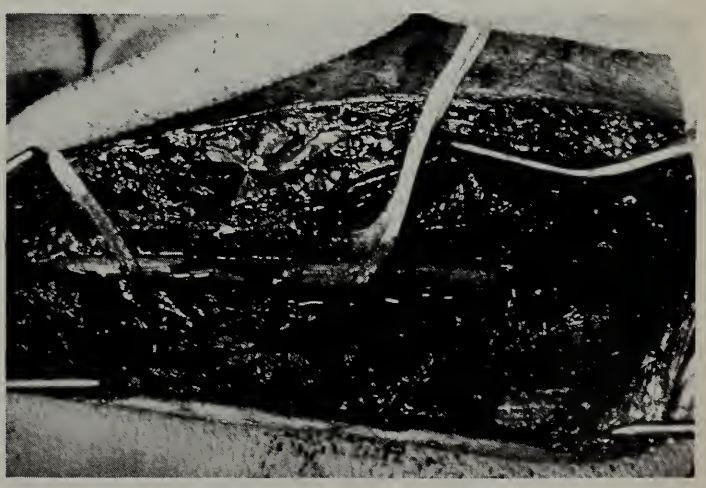


Fig. 3.—An intraoperative photograph of the radial nerve, exposed just proximal to the elbow, demonstrates mild fusiform swelling between the two umbilical tapes. This neuroma-in-continuity was firm to palpation.

Electrical stimulation proximal and distal to the neuroma failed to elicit muscular contraction. NAPs were recorded over a segment of nerve proximal to the neuroma (Fig. 4) and were normal. Stimulation distal to the neuroma, however, failed to produce a proximal NAP. As these findings indicated that no axonal growth across the neuroma had occurred, the lesion was resected until grossly normal neural architecture was identified. Since a 3.5 cm gap was present, a graft was performed utilizing autologous sural nerve and the operating microscope (Fig. 5).[4] The arm was casted in a flexed position to prevent tension across the nerve anastamoses.

Pathological examination of the resected neuroma revealed abundant fibrotic tissue with relative preservation of the external neural architecture. Myelin and axonal stains confirmed the absence of neural regeneration through this segment (Fig.. 6).

The patient was unavailable for follow-up examination but telephone interview nine months postoperatively indicated that he had good wrist extensor function. This would seem to indicate functional growth of axons through the nerve grafts.

Case 2.—This 20-year-old white male sustained a gunshot wound to his left knee in March 1983 with immediate onset of a complete common peroneal nerve palsy. He underwent superficial wound debridement elsewhere and was observed for three months without neurologic improvement. Examination then revealed a positive Tinel's sign in the left popliteal fossa. The tibialis anterior, peroneus brevis and longus, and extensor hallucis longus were plegic. Decreased sensation was noted over the lateral aspect of the left calf and the dorsal left foot. As the examination was still consistent with a complete common peroneal nerve palsy, surgical exploration was undertaken.

At surgery, the sciatic nerve was exposed 15 cm proximal to its bifurcation and the peroneal nerve was followed distal to the knee. A neuroma-in-continuity involving the common peroneal nerve was identified. Nerve action potentials were recorded across this lesion indicating axonal regrowth (Fig. 7). Surgical resection was, therefore, not performed. Examination seven months later revealed a Tinel's sign 12 cm distal to the fibular head. Motor examination showed a −1 tibialis anterior, −2 peronei, and −4 extensor hallucis longus. This indicated axonal regrowth through the area of nerve injury.

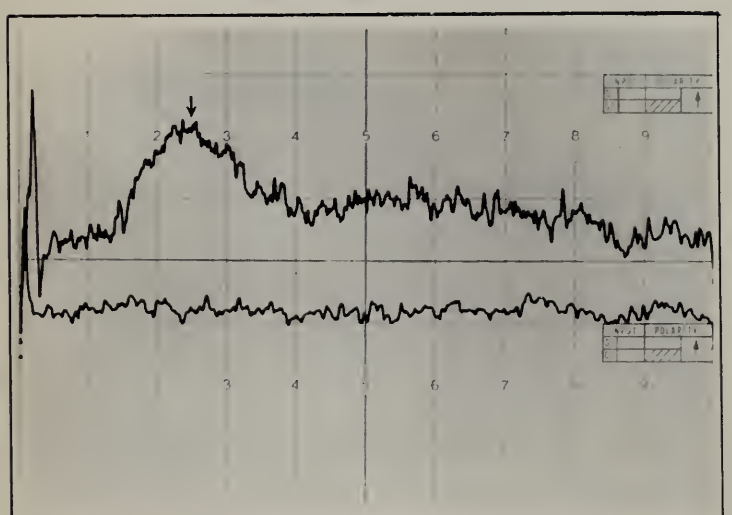


Fig. 4.—Stimulation and recording proximal to the neuroma yielded a nerve action potential (upper trace, arrow). Stimulation proximal and recording distal to the neuroma revealed no evidence of an NAP (lower trace).

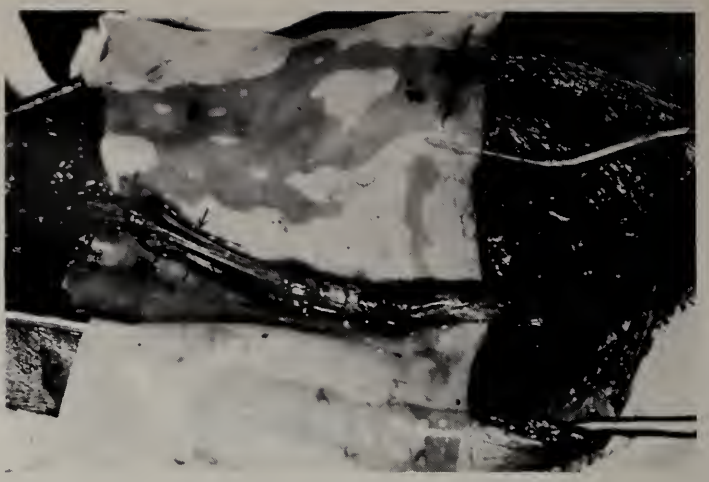


Fig. 5.—Intraoperative photograph shows sural nerve grafts in place (arrow).

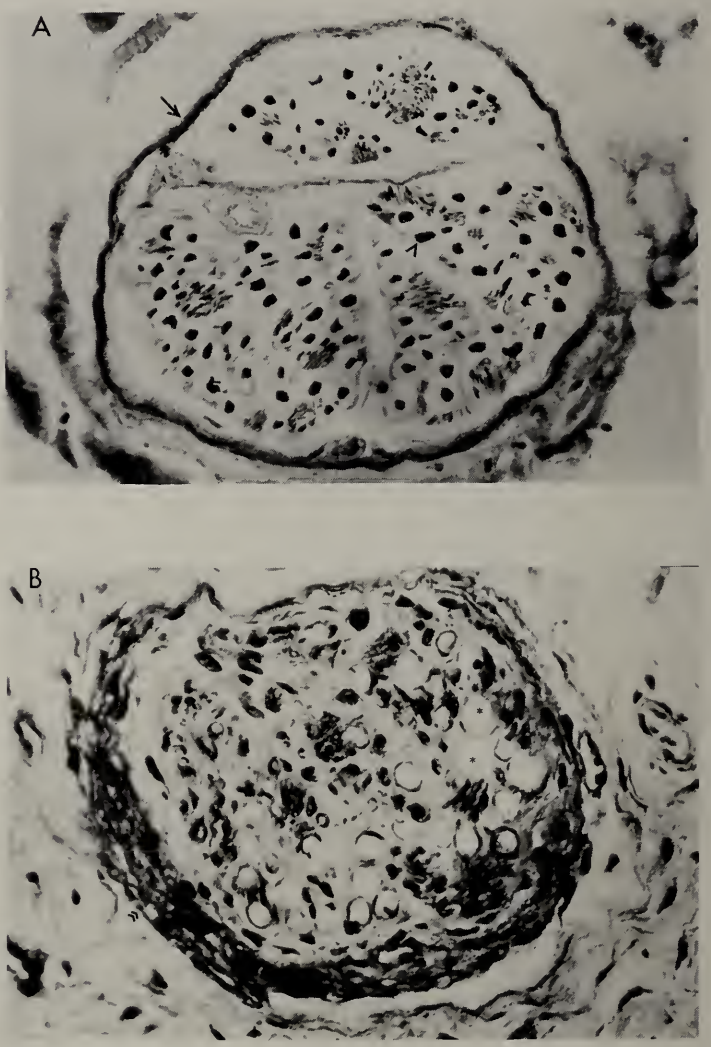


Fig. 6.—A. This photomicrograph shows a normal nerve fascicle. Note the normal black staining axons (arrowheads) surrounded by myelin. The surrounding perineurium is normal thickness. B. A photomicrograph of the neuroma-in-continuity demonstrates a loss of axons with vacuolization (asterisks). The surrounding perineurium is markedly thickened and scarred (double arrowhead).

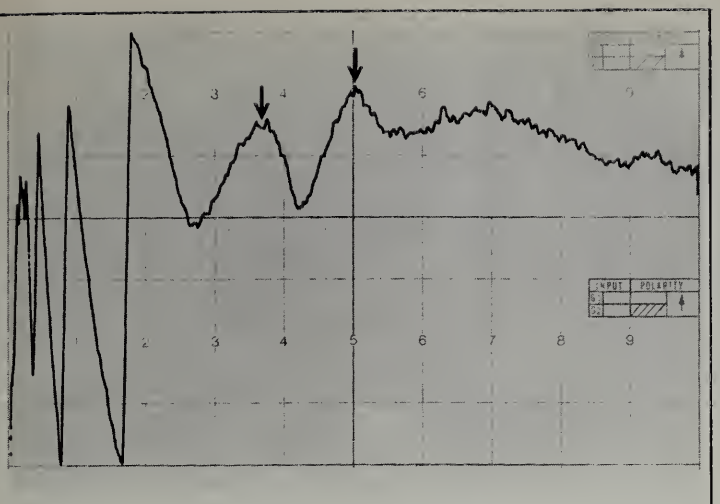


Fig. 7.—Stimulation proximal and recording distal to the neuroma yielded this polyphasic NAP (arrow).

Discussion • Peripheral nerve injuries are often classified as neuropraxia, axonotmesis, or neurotmesis. Neuropraxia is a reversible injury in which there is a variable loss of distal function. The causes are thought to include local electrolyte imbalance, neural ischemia, and compressive-shear forces of an acute or chronic nature.[5] If chronic compression is present local myelin alterations may be evident ultrastructurally. In this situation neurolysis may be required to restore neural function. Neuropraxia secondary to acute trauma generally improves without surgical intervention within a six week period (usually within days). If neuropraxia is present, axonal dysfunction is only found at the site of injury; hence, stimulation of the nerve distal to the injury will produce muscle contraction. Nerve action potentials can be generated above and below the injury site but will not be conducted across that area.

Axonotmesis is a pathological process of increased severity including loss of axons and myelin with preservation of the surrounding connective tissue elements. The continuity of these structures provides a pathway by which axonal regrowth can effectively occur.[3] The time needed for restoration of function after axonal destruction is determined by the rate of regrowth and the distance from the site of injury to the point of muscle innervation. Axonal regeneration is known to progress at approximately 1 mm per day.[6] Thus at two months after injury sufficient time has passed for growth but not necessarily restoration of muscle function. Depending upon the aforementioned factors, nerve stimulation may or may not produce muscle contraction. Nerve action potentials will, however, be conducted across the area of injury if axonotmesis, with subsequent regeneration, is present. As this natural process of reinnervation is much more efficient than that which occurs in a transected and sutured nerve, a neuroma-in-continuity should not be resected if axonotmesis is identified with NAPs.[1]

The more severe type of peripheral nerve trauma is neurotmesis. Pathologically, the axons and myelin are destroyed with additional disruption of the surrounding connective tissue structures. A nerve transection is a form of neurotmesis but the nerve can also be in continuity. In this situation, the potential pathway of neural regeneration has been ablated.[3] Stimulation of the nerve either proximal or distal to the neuroma will not produce muscle contraction and since there is no axonal regrowth nerve action potentials will not be conducted across the neuroma. As no functional recovery can be expected, the demonstration, with NAPs, of a neurotmetic neuroma-in-continuity is an indication for resection with nerve anastamosis.

Two months after peripheral nerve trauma producing a complete loss of distal function, the injured area is usually swollen in a fusiform manner. This gross appearance, termed "neuroma-in-continuity," is consistent with the internal pathologic process of either axonotmesis or neurotmesis. When nerve stimulation failed to elicit muscular contraction, it was formerly very difficult to decide whether to resect such a lesion. With the advent of intraoperative NAP testing, this decision has become clear-cut. The presence of NAPs across an injured area indicates that axonal regeneration is occurring and that the muscles will eventually be reinnervated.[2] The absence of NAPs indicates that functional regeneration will not occur unless the neuroma is resected and the nerve ends anastamosed. It is fair to say that nerve action potential testing is currently indispensable in the operative management of peripheral nerve injuries.

References

1. Kline, D.G.: Physiologic and Clinical Factors Contributing to Timing of Nerve Repair, Clin. Neurosurg. 24:425-455, 1977.
2. Kline, D.G. and Hackett, E.R.: Value of Electrophysiologic Tests for Peripheral Neuromas, J. Surg. Oncol. 2(3):299-310, 1970.
3. Kline, D.C. and Nulsen, F.E.: Acute Injuries of Peripheral Nerves. In Youmans, J.R. (ed), Neurological Surgery. Philadelphia, W.B. Saunders, 1982, pp 2362-2474.
4. Mallesi, H.; Meissl, G., and Berger, A.: Interfascicular Nerve Grafting of Ulnar and Median Nerves, J. Bone Joint Surg. 54A:727-750, 1972.
5. Spinner, M.: Injuries to Major Branches of Peripheral Nerves in Forearm, Philadelphia, W.B. Saunders, 1978, pp 26-39.
6. Sunderland, S.: Rate of Regeneration of Peripheral Nerves, Arch. Neurol. Psychiat. 58:251-296, 1947.

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Noninvasive cerebrovascular screening for carotid extracranial cerebrovascular disease in the stroke-prone patient

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ABSTRACT: It appears that the use of continuous wave Doppler scanning (including spectral analysis and directional flow studies) accomplished in tandem with visualization of the vessel by B-mode real time scanning has enhanced the reliability of noninvasive study of patients who have symptoms suggestive of cerebrovascular insufficiency.

In our studies of 100 extracranial carotid artery systems, the Doppler and B-mode scan correctly identified patients with significant pathology in 97% of arteries. These methodologies represent a rapid, relatively safe, reliable and reproducible mechanism of assessing the extracranial carotid artery circulation in patients possibly warranting arteriography. This development is notable in the "stroke syndrome" which is one of the three major causes of death and disability in the United States.

The Authors

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Dr. Green is a faculty member of the Florida Neurological Institute; Dr. Brinson is on the staff at University Hospital as a resident in the Department of Medicine; and Mr. Driber, Mr. Baugh and Ms. Wallace are faculty members of the Florida Neurological Institute, Jacksonville.

This report reviews the current status of the combined utilization of continuous wave Doppler scanning and B-mode real time scanning in the clinical and laboratory evaluation of stroke-prone patients. These are patients who may have significant arteriosclerotic involvement of the extracranial carotid artery systems. We tested the correlation of "positive" arteriographic findings in patients subject to an arteriographic (invasive) procedure with findings noted on the Doppler scan and B-mode scans (noninvasive) done in a combined fashion.

Egas Moniz in 1937 reported invivo evaluation of patients with extracranial carotid artery cerebrovascular disease via carotid arteriography.[1] C. Miller Fisher in 1951 documented postmortem extracranial carotid disorders in patients with "stroke syndrome."[2] Spencer et al in 1974 promulgated a noninvasive methodology of studying extracranial carotid artery circulation via the continuous wave Doppler scan.[3] Multiple refinements including spectral array frequency analysis have lead to the increased accuracy of this procedure to approximately 80-90%.[4,5]

We suggest that in tandem Doppler scanning including spectral frequency analysis and B-mode real time scanning further refines noninvasive extracranial carotid artery studies. The primary problem heretofore encountered with Doppler continuous wave scanning was nonvisualization of small but potentially damaging ulcerated plaques.[5] This has been significantly rectified by in tandem utilization of the B-mode real time imaging system.

The methodology in this report is noninvasive, reliable, reproducible, and reasonably safe for further defining the patient in need of cerebral angio-

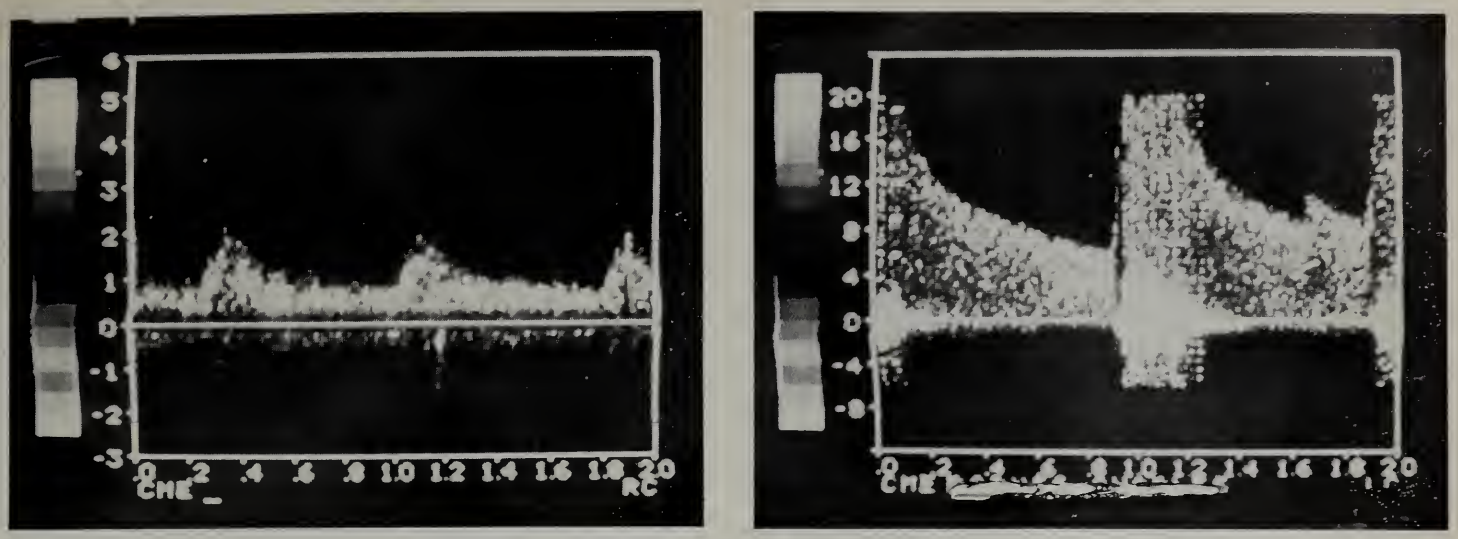


Fig. 1. — Normal Doppler spectral frequencies of the origin of the ICA (left). Doppler spectral frequencies in a severe stenosis where the systolic frequency is above 10 kHz and the diastolic frequency is 12-15 kHz (right).

graphy, an invasive procedure with a defined risk.[6,7] Once identified the stroke-prone patient may be benefited by reparative surgery of extracranial carotid artery disease (i.e. stenosis and/or plaque formation).[8-10]

Materials and methods • Fifty patients with symptoms suggestive of cerebrovascular insufficiency, both men and women aged 32 to 87 representing 100 extracranial carotid systems, were studied by both clinical and laboratory means. A detailed history was obtained and complete physical examination including neurological was performed on all patients along with bilateral brachial blood pressure determinations and a search for cervical and intracranial vascular bruits by auscultation.[11]

All patients had complete studies of the extracranial carotid circulatory systems via Doppler (Dop scan 150) (Fig. 1) and B-mode real time scans (Fig. 2-3). An individual spectral frequency analysis via Doppler was accomplished for each carotid artery studied and an evaluation for directional ophthalmic arterial flow patterns was recorded bilaterally. Possible decreases were sought in individual frontal artery flow pattern via compression maneuvers of the temporal, facial and common carotid vessels.

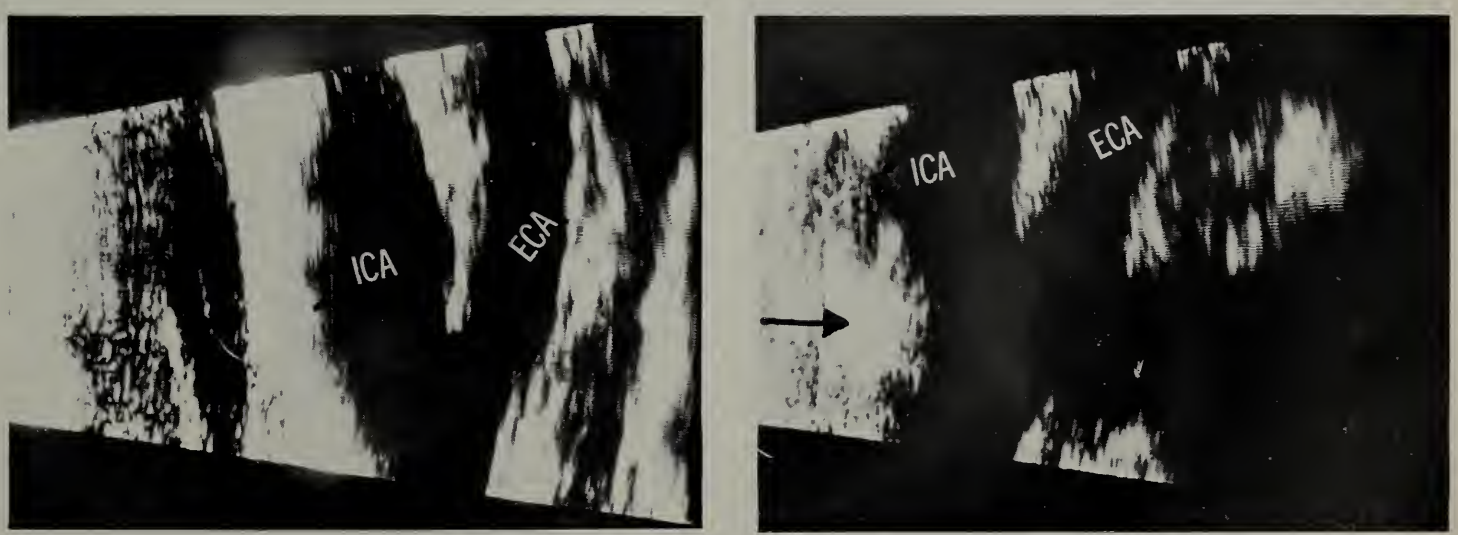


Fig. 2. — Normal carotid bifurcation (left). Longitudinal bifurcation, posterior-anterior approach. Echogenic atheroma (arrow) at the origin of the ICA. Note the far field acoustic shadow (right).

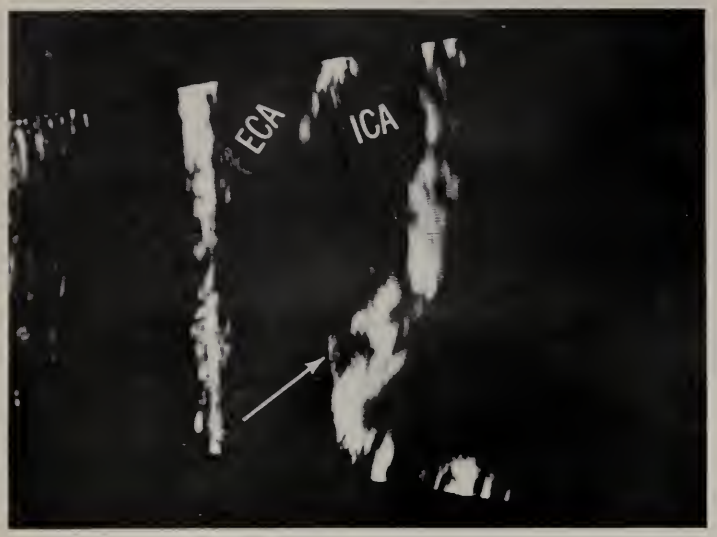


Fig. 3.—Carotid bifurcation anterior-posterior approach. Note the calcific plaque at the origin of the internal carotid. A large-ulceration with a moving intimal flap (arrow) was noted.

Discussion • Excluded from our study were patients who had clear indication for rapid performance of cerebral arteriography, i.e. those presenting either with rapidly recurring transient cerebral ischemic attacks or cerebral thrombosis in evolution.[12] Selected were those who had signs or symptoms only suggestive of extracranial carotid cerebrovascular insufficiency including possible transient cerebral ischemia, i.e. vague unilateral extremity weakness and/or weakness without pain in which cerebrovascular features were not clearly present. Also included were patients with known compeleted (significant) brain infarction (hemiplegia, aphasia, etc.) in which arteriography had not been carried out and those with asymptomatic carotid bruits.[13] Patients who had arteriographic demonstration of unilateral extracranial internal carotid artery disease surgically corrected were followed for possible progression of an opposite side mildly involved vessel as demonstrated by angiogram. These nonoperated but angiographically visualized vessels initially showed less than a 50% luminal compromise and no ulcerated plaques were present.

A number of previous studies have validated the continuous wave Doppler scan as a useful screening technique for possible extracranial carotid disease.[14,15] Most attest to its safety, reliability and reproducibility.[16] These studies suggest at least 80% to 90% reliability when dealing with a stenosis and over 50% in arteriosclerotic narrowing in the extracranial carotid artery system. A number of reports comment on the inability of the system to detect plaques of less than 50% stenosis with ulceration.[4,13] This failure was regarded as the main shortcoming of the system used alone. Anatomical variation of the external carotid artery in as much as 5% of cases also appeared to add to the inability to achieve an almost "100% reliable" correlation with angiography.[17-19]

Table 1. — Noninvasive study results as compared to angiogram

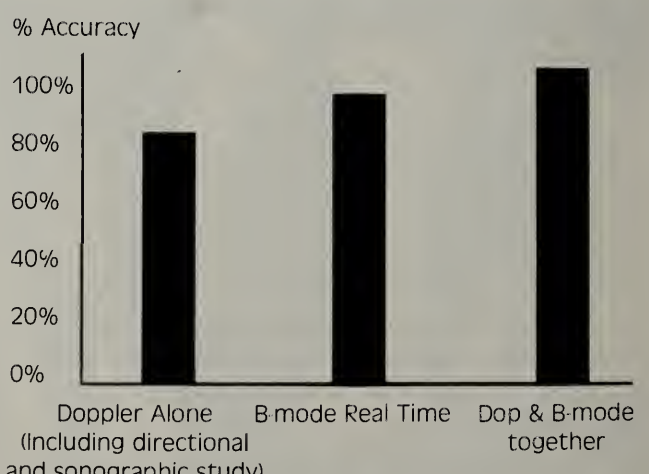
1. 97% overall accuracy in patient with both studies
2. 0% false negatives in patients with both studies
3. 3% false positives in patients with both studies

The additional method of B-mode real time scanning appears to reasonably cover the diagnosis of the significant ulcerated plaque, the single most likely "missed lesion" by utilization of the Doppler system alone.[20]

Prior studies correlating the findings of Doppler scanning associated with angiographic data suggest a greater degree of reliability of the audio frequency spectral analysis as opposed to only the visual mapping of a vessel.[21] The initial empahsis on audio frequency subsequently led to development of an analog to digital display of the spectral analysis of the audio frequency systems. Earlier investigators built analyzers (pass through filters) that only identified "abnormal" frequencies which allowed this test to be performed for the most part by technician level personnel.[22]

The importance of noninvasive studies of the extracranial carotid system is recognizable in that there is at least a 50% occurrence of significant bifurcation disease in patients with acute brain infarction.[4] The utility of the system has also been shown to increase with the clinical presence of a carotid bruit.[20]

Table 2. — Arterial correlation.



A total of 100 vessels were studied utilizing Doppler and B-mode real time scanning procedures. Eighty three percent of patients with abnormal Doppler studies and 92% with abnormal B-mode real time scan also had an abnormal carotid arteriogram.

Heretofore the only reliable system for evaluating the extracranial cerebral vasculature was cerebral angiography; a procedure known to have definitive risks. It also did not fulfill the criteria of being relatively inexpensive.

We found that utilization of ancillary techniques such as determination of the direction of the ophthalmic artery flow associated with the use of digital compressive maneuvers of frontal, temporal, facial and carotid arterial vessels does enhance the overall reliability of our (ECAD) system findings (as judged in finality by comparison to cerebral angiography.) Data supplied by arterial compressive techniques taken in light of the clinical condition of the patient have also raised our diagnostic methodology's overall accuracy (angiogram — invasive as compared to noninvasive modalities). Surgeons suggest that the lesions found by noninvasive B-mode studies in most cases so far have been closer to the actual operative pathology than the cerebral angiogram. This may be explained on the basis of the 135° arc of "visulization" by the B-mode real time scan showing well the most likely location of the plaqueing and ulceration in the posterior and medial wall of the extracranial carotid vessel. The usual angiographic studies are limited traditionally to AP and lateral views of the carotid arteries only.

There appears to have been an historical progression from the technique of simple ophthalmodynometer to the continuous wave Doppler in the quest for reliable noninvasive studies in extracranial vascular disease.[22-24] Less risky definitive invasive studies such as digital angiography may yet hold further valuable information in the assessment of the potential "stroke" prone patients.

Complications in our studies to date have included one case of retinal detachment possibly related to determination of ophthalmic directional Doppler imaging and one case of extracranial carotid-cerebral embolization which occurred while imaging the cervical carotid vasculature with a Doppler probe.

Summary • It appears that the use of continuous wave Doppler scanning (including spectral analysis and directional flow studies) accomplished in tandem with visualization of the vessel by B-mode real time scanning has enhanced the reliability of noninvasive study of patients who have symptoms suggestive of cerebrovascular insufficiency.

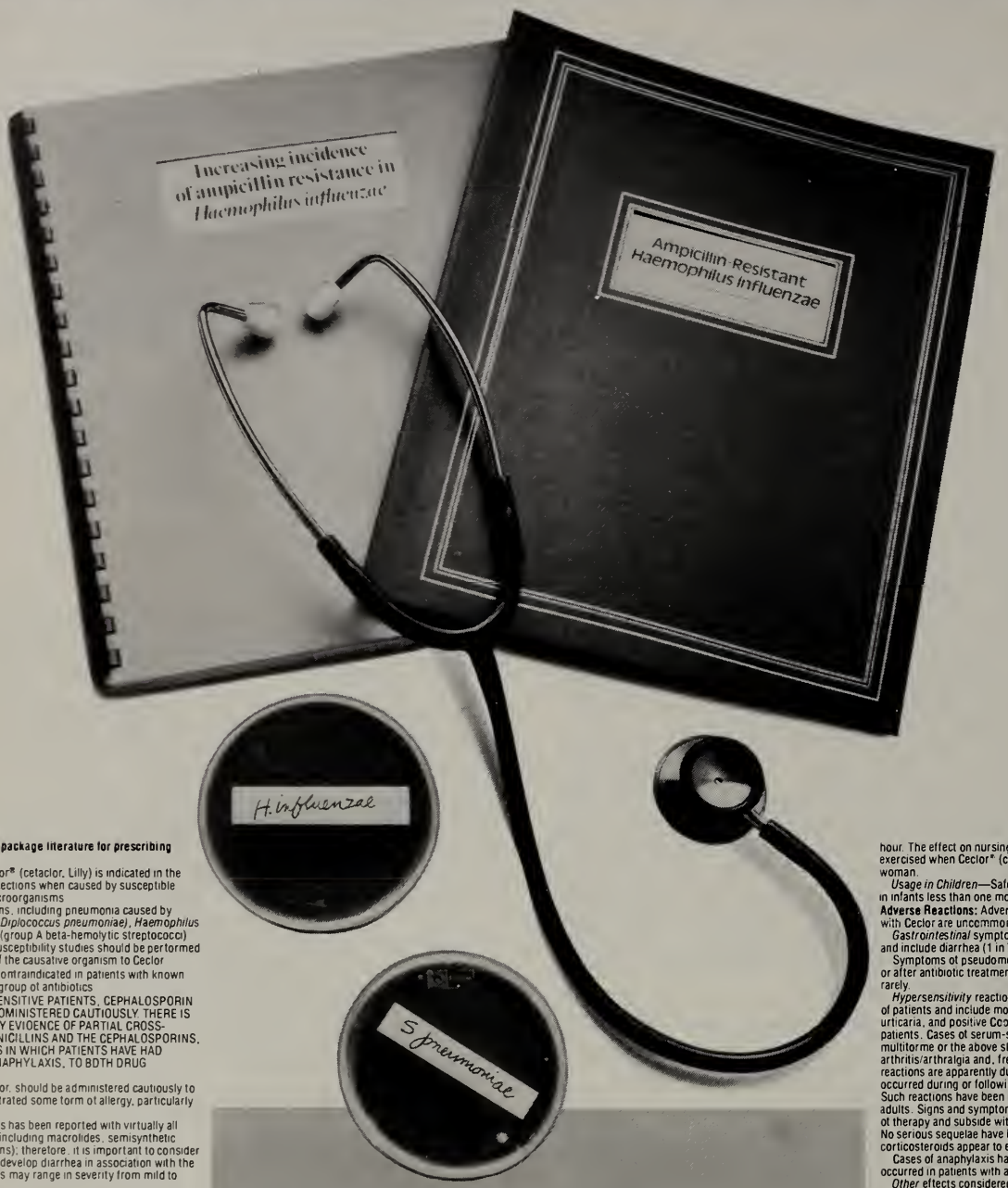
In our studies of 100 extracranial carotid artery systems, the Doppler and B-mode scan correctly identified patients with significant pathology in 97% or arteries. These methodologies represent a rapid, relatively safe, reliable and reproducible mechanism of assessing the extracranial carotid artery circulation in patients possibly warranting arteriography. This development is notable in the "stroke syndrome" which is one of the three major causes of death and disability in the United States.

References

1. Moniz, E. and Lima, A.: de Lacerdar Hemiplegies par Thrombose de la Carotide Interne, Presse Med. 45:977-980, 1937.
2. Fisher, C.M.: Occlusion of Internal Carotid Artery, Arch. Neruol. Psychiat. 64:346-377, 1951.
3. Spencer, N.P.; Reid, J.M.; Davis, D.L., et al: Cervical Carotid Imaging with Continuous Wave Doppler Flow Meter, Stroke 5:145-154 (March-April) 1974.
4. Baskett, J.J.; Beasley, M.G., et al: Screening for Carotid Junction Disease by Spectral Analysis of Doppler Signals, Cardiovascular Research 11:147-155, 1977.
5. Shoumaker, R.D. and Block, S.: Cerebrovascular Evaluation: Assessment of Doppler Scanning of Carotid Arteries, Ophthalmic Doppler Flow and Cervical Bruits, Stroke 9(6):563-566 (Nov.-Dec.) 1978.
6. Admundsen, P.; Dietrichson, P.; Enge, I., et al: Cerebral Angiography by Catherization — Complications and Side Effects, Acta Radiol. (Diagn.) 4:164-172, 1963.
7. Cronovist, S.; Efsing, H., and Palacios, E.: Emboli Complications in Cerebral Angiography with Catheter Technique, Acta Radiol. (Diagn.) 10:97-107, 1970.
8. Eastcott, H.H.G.; Pickering, G.W., and Rob, C.G.: Reconstruction of Internal Carotid Artery in Patient with Intermittent Attacks on Hemiplegia, Lancet 2:994-996, 1954.
9. Coulan, D.A.; Al-Naaman, Y.D., and Carlton, C.A.: Surgical Treatment of Arteriosclerotic Occlusion of Common Carotid Artery, J. Neurosurg. 13:500-506, 1956.
10. Kindt, G.W. and Youmans, C.J.: Effective Stricture on Length of Critical Arteriostenosis, SG&O 128:729-734.
11. O'Toole, J.F. and Patel, A.: Interview and Neurovascular Examination in Cerebrovascular Disorders, New York, McGraw-Hill, pp. 72-91, 1974.
12. Green, J.: Temporal Profile Differential Diagnosis of Stroke, JFMA 59:17, 1972.
13. Zeigler, D.K.; Zozileli, T; Dick, A., et al: Correlation of Bruit Over the Carotid Artery with Angiographically Demonstrated Lesions, Neurology 21:863-865, 1971.
14. Blackwell, E.; Merory, J.; O'Toole, J.S., and McKinney, W.: Doppler Ultrasound Scanning of Carotid Bifurcation, Arch. Neurol. 34:135 (March) 1977.
15. White, D.N.; Curry, G.R.(N); White, D., and Lyons, E.A.: EDS: Ultrasound in Medicine, New York, Plenum, 4:363-376, 1978.
16. Barnes, R.W.; Bone, G.E.; Reinertson, et al: Noninvasive Ultrasound Carotid Angiography: Prospective Validation by Contrast Arteriography, Surgery 80-328, 1976.
17. Prendes, L.; McKinney, W.; Buonanno, F., and Jones, A.M.: Anatomical Variations of Carotid Bifurcation Effecting Doppler Scan Interpretations, J. Clin. Ultrasound 8:147-150 (April) 1980.
18. Green, J.: Forehead Pallor Test, Dis. Nervous System 36:425-426, 1975.
19. Grossman, B.L. and Wood: Evaluation of Cerebrovascular Disease Utilizing Transcutaneous Doppler Technique, Radiology 90:586, 1968.
20. Comerota, J.J.; Cranley, J.J., and Cook, S.: Real Time B-mode Carotid Imaging in Diagnosis of Cerebrovascular Disease, Surgery 89(6):718-729, (June) 1981.
21. Bloch, S.; Baltaxe, H.A., and Shoumaker, R.D.: Reliability of Doppler Scanning of Carotid Bifurcation, Angiographic Correlation, Radiology 132(3):687-691 (Sept.) 1979.
22. Griggs, William III: Personal communication.
23. The Harvard Medical School Health Letter, September 1981.
24. Croft, R.J.; Ellam, L.D., and Harrison, M.G.: Accuracy of Carotid Angiography in Assessment of Internal Carotid Artery, Lancet 1:97-1000, 1980.

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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
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Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]
Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II:880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979

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SPECIAL ARTICLE

The Florida Legislature: The need for change

David J. Lehman, M.D., State Representative

After serving nine and a half years in the Florida legislature, several problems related to the legislative process have become apparent to me.

How effective is the legislative process? What changes might improve the process and, therefore, benefit Florida citizens?

The legislature needs a greater diversification of members. As an example, physicians and other health care professionals rarely run for a seat in the legislature. This may be due to the low salary and the necessity to reduce the size of their practices. There has been no increase in salary since 1968. There are many attorneys serving in the legislature. It is well known that some of them are often offered a position in a prestigious law firm or selected as city or county attorney when they leave the legislature. Or, if they choose private practice, client referrals may exceed those made to the average attorney. Some attorney-legislators have been assistant state attorneys or public defenders, positions considered political stepping stones.

The method of choosing the Speaker of the House and the President of the Senate must be changed. The present system allows one or more legislators in the majority party to solicit pledges years in advance of the term which they are seeking. As an example, there are members who have already filed the necessary papers for the Speaker's race for 1988 and 1989. The Speaker eventually chosen will have made many commitments to the members who signed pledges of support. This is counter productive to the legislative process. A better method would be to select Speakers and Presidents by closed ballot of voting members of the majority party. Each legislator would write the name of his or her preference on an unsigned ballot. The top two vote getters would then be voted upon by another closed ballot. The winner, therefore, would not know who had voted for him or against him. The runner-up would become the Speaker pro tempore. No signed pledges would be allowed. The selection of committee chairmen would more likely be based on ability rather than a prior commitment to obtain a vote.

I have witnessed many instances where meaningful legislation has not been debated on the floor of the House because of the enormous power of the Speaker and the legislators close to him...

I have witnessed many instances where meaningful legislation has not been debated on the floor of the House because of the enormous power of the Speaker and the legislators close to him, for example, the chairman of the Rules Committee. Bills passed through the committee process may never be placed on the Special Order Calendar by the Rules Committee because the Speaker does not like a particular bill. Another method used to kill a bill is for the Speaker to refer it to several committees and instruct

The Author
REP. DAVID J. LEHMAN, M.D.
Dr. Lehman is State Representative for District 98.

the chairman of one or more not to pass the bill. This is an effective method for using a "pocket veto," and the full House never debates the merits of the bill.

The Florida Senate is well known for its record of killing bills that have passed the House by just not acting on them. It is inexcusable that House and Senate leadership and the Governor cannot agree on major legislation year after year, thereby forcing the legislature into multiple special sessions at great cost to the taxpayers. This process is called "political posturing," further evidence of lack of leadership. I remember a few years ago when the Senate adjourned "sine die" while the House was still debating the appropriations bill. This action was both unfair and devious and resulted in multiple special sessions. This has led me to believe that a unicameral legislature made up of 40-50 members would be superior to the present legislature. It would be cost effective and major legislation would have a better chance of passing. It might also serve to reduce the amount of legislation that often passes at the request of "special interest groups."

In 1977 Speaker Don Tucker recognized the need for the legislature to take positive action against the many organized crime figures who had moved into Florida. He formed a "Select Committee on Organized Crime" and I served on this committee. Our main recommendation was to create a Commission of Investigation with a Special Statewide Prosecutor to conduct public hearings throughout Florida to identify, target, indict, and prosecute organized crime figures. In 1978 the House of Representatives passed CS/HB 686, a bill I had introduced creating a Commission of Investigation and Special Prosecutor. Senator Robert Graham was unsuccessful in passing a companion bill through the Senate. Governor Reubin Askew also refused to support this bill. The Committee interviewed many individuals from New Jersey and the Executive Director of the New Jersey Commission of Investigation stated that, because of their Commission's public hearings, most of New Jersey's crime figures had moved to Florida. He stated that "open hearings are far superior to the proceedings of a Statewide Grand Jury which conducts its investigations behind closed doors." In Florida, our Statewide Grand Jury proceedings are very expensive and often unsuccessful in indicting organized crime figures.

It is of interest to note that the prosecutor of Florida's Statewide Grand Juries is a State Attorney from one of the 20 judicial districts.

It is of interest to note that the prosecutor of Florida's Statewide Grand Juries is a State Attorney from one of the 20 judicial districts. The reason this legislation did not pass the Senate or receive gubernatorial support was because the Florida Association of State Attorneys lobbied intensely and effectively against the bill. I have recently spoken to Governor Graham and Attorney General Jim Smith about reintroducing this bill and they have refused to support it. This is an example of how a small special interest group can effectively defeat meaningful legislation. Special Grand Jury reports in south Florida have all recommended new vigorous approaches to rid this state of organized crime figures. Their pleas have fallen on deaf ears.

In summary, some or all these recommended changes might help; however, knowing the political process in Tallahassee as well as I do, it is highly unlikely that they will take place in the near future.

● Dr. Lehman, Suite 104, Center Court Building, 2450 Hollywood Boulevard, Hollywood 33020.

Some reflections on responsibility, 1956-1984

Norman M. Kenyon, M.D.

I am honored and privileged to address the 1984 graduates of the University of Miami School of Medicine. The title of the first commencement address in 1956 was "Some Reflections on Responsibility." It is appropriate that we inventory these responsibilities as the affect us all, both past and present. The responsibilities of the University of Miami and the University of Miami School of Medicine in 1956 have been met and continued in spectacular fashion to the present. We must applaud Dean Homer F. Marsh who began with a class of 28 students in 1952 and graduated 26 medical doctors in 1956. This was accomplished within the limited quarters of the old Veterans Administration Hospital in Coral Gables and Jackson Memorial Hospital. During that four year period, the University of Miami and Dr. Marsh shunned uncertainty and developed a clinical faculty and accommodated a student body that grew each year. This achievement was quite remarkable considering the financial constraints and problems of a young university.

John Robinson, M.D., joined the faculty during this period of growth as the Director of the new outpatient facilities in 1955. I can assure you that this marvelous physician and outstanding human being has changed little since his arrival at the University of Miami School of Medicine and continues in his sincere and caring relationship with students. George H. Paff, Ph.D., was a professor of anatomy who taught in a tough, stimulating, but fair manner. Dr. Paff insisted that his students "know their stuff." These outstanding faculty members enjoyed universal respect and admiration of the student body. The preliminary annual alumni seminars were named after Dr. Paff and the fund-raising portion of the University of Miami School of Medicine Alumni Association is appropriately named the John Robinson Loyalty Fund. We are fortunate to have many outstanding faculty members encompasisng all specialties of medicine who have contributed greatly to the growth and prestige of the University of Miami School of Medicine. These outstanding individuals have and will continue to meet their responsibilities. Some of the original faculty members present with us today are Bennett Sallman, Ph.D.; Peritz Scheinberg, M.D.; Jonathan Braunstein, M.D.; Ryan Chandler, M.D.; Nancy Noble, Ph.D., and George Tershakovic, M.D.

The School of Medicine has exhibited continued growth and forged a relationship with Jackson Memorial Hospital in the form of the Public Health Trust that benefits the community, our nation, and the international community with advances in health care. It is a privilege for us to have had the opportunity to learn and grow as participants within the outstanding medical facilities based at the University of Miami School of Medicine and Jackson Memorial Hospital. As graduates, we are representatives of the University of Miami and have taken our places throughout the United States. I am unable to name all of our outstanding graduates, but I can assure you that they have met their responsibilities.

One of the recent highlights has been the appointment of 1961 University of Miami School of Medicine graduate, through the wisdom of President

The Author
NORMAN M. KENYON, M.D.
Dr. Kenyon is a General Surgeon in Miami.

Foote, as Dean of the University of Miami School of Medicine to follow the pattern of excellence established by Dean Emanuel Papper. Dean Bernard Fogel has accepted the challenges and responsibilities for all of us in charting the future activities of our Medical School. Thank you President Foote!

You, the Class of 1984, are graduating from one of the finest medical schools in the United States. Your educational credentials are second to none. The uncertainties that trouble all of us now are the changing political patterns of the United States in the public awareness of medical care. Expectations of excellent care and universal good results for all medical problems are commonplace. Changes are occurring in reimbursement concepts for medical care. Medicare's Diagnostic Related Groups System institutes absolute discrimination in the funding for medical care involving patients over age 65 or included in the Medicare System. It is important that we not allow ourselves to follow this restrictive pattern in our management of elderly patients or any group of individuals irrespective of their resources or type of health care coverage. Pain, illness, and death continue in spite of medicine's best efforts. The outright fury and aggressive behavior of cancer patients and their families develop from the cost, pain, and frustration of less than ideal or unsuccessful treatment. We all have had a friend or close family member succumb to malignancy during heroic and aggressive treatment. As you assume your responsibility of patient management, you will feel the pain and agony of unsuccessful treatment on your part. Subsequent malpractice suits for maximum and total responsible treatment have an unbearable impact when you know everything was done for the benefit of the patient. We grudgingly accept brutal medical statistics on the treatment success of malignancies, infections and trauma. All too frequently, patients and their families are subjected to indifferences and uncaring attitudes to discomforts endured in their protracted and uncomfortable investigations and treatments.

Total responsibility for patient care is the medical training goal for each and every one of you to achieve.

Total responsibility for patient care is the medical training goal for each and every one of you to achieve. I think several basic concepts must be taken into consideration as we assume these heavy responsibilities. First and foremost, we are healers and realize that every patient will not be cured or aided. Health involves the future and, accordingly, the anguish and inner resources required to live with and adapt to pain, sickness, and death. We must communicate in a humble fashion that we are unable to achieve complete success in dealing with malignancy, infection, and trauma in spite of many marvelous new drugs, diagnostic and therapeutic devices. We can examine individuals every day of their lives and not prevent cancer. All therapeutic modalities and personal resources can be expended and not succeed in achieving a cure. Patients must become informed and aware of the limitations of medical care. Only in this fashion will people who have undergone extensive diagnostic studies comprehend an unexpected malignancy or a major health catastrophe that occurs without warning or objective findings.

It would seem that everyone wants to practice medicine today, the legislators, lawyers, insurance companies, hospitals, the Federal Trade Commission, health maintenance organizations, preferred provider organizations and peer review groups. Third parties and hospitals of necessity are involved with unit costs and utilization of medical facilities. We are privileged to participate in birth, illness, and death, and are intimately involved with people and their families. You are the only trained and credentialed individuals who can practice medicine. The only true advocates for patients are physicians and their loved ones. This is becoming one of our greatest responsibilities as the new health-care laws proliferate. More than ever before, we must be concerned in caring for the patient within the health delivery system.

Informed people (patients) eventually recognize and move to correct the inadequacies and deficiencies within the health-care bureaucracy. As you grow and develop in the practice of medicine, I consider several responsibilities to be of the utmost importance. We will never cease to be students. This applies to all graduates from colleges of Medicine as well as practicing physicians. We must be involved and educate our fellow physicians and students. In discussions, we are always able to agree on factors concerning the well-being of our patients. Avoid concerns not related to patient care as they divide the medical community.

I urge you to support the University of Miami to the best of your ability. We are a part of the University and together we can continue to strengthen and advance our medical school. To love our fellow man is to respect his or her dignity. We must treat the person as an end in himself, not as a tool or entity to be manipulated, degraded or discarded. In administering your great knowledge and skill with patients, be proud to let a little love show through.

● Dr. Kenyon, 9855 SW 69th Ave., Miami 33156.

FLORIDA MEDICAL

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NOTES & NEWS

Hippocratic Award for exemplary teaching goes to two University of Florida faculty physicians

For the first time in its 15-year history, the annual Hippocratic Award for exemplary teaching in clinical medicine is being shared by two faculty physicians in the University of Florida's College of Medicine.

Senior class members presented the traditional award to James Ocie Harris, M.D., Professor of Medicine, and Elia M. Ayoub, M.D., Professor of Pediatrics and of Immunology and Microbiology, whom they selected for best displaying the ideals of Hippocrates in compassionate patient care and effective teaching.

Presentation of the award took place May 9 in a special ceremony held under the Tree of Hippocrates in front of Shands Hospital's new Patient Services Building. The sycamore was brought from the legendary Father of Medicine's homeland in Greece and has flourished as a symbol of the medical profession's dedication to his example as a teacher and clinical practitioner.

In presenting the award to Dr. Harris, Kathy Boynton praised not only his dedication to his students and his profession but to his love of life and of the outdoors. "Did you know that Dr. Harris listens to bird calls on his way to work? As his students, we learned almost as much about bird calls as we did about the lungs," Boynton said.

Dr. Harris is Chief of Pulmonary Medicine at Gainesville's Veterans Administration Medical Center, chairman of the Department of Medicine's medical student education committee and was chairman of the College of Medicine's medical student selection committee from 1979 to 1983.

Dick Deibert presented the award to Dr. Ayoub, saying, "It is not only his interest in us as students, but in us as people, which makes us so fortunate to have his guidance and friendship. Not one of us has not spent time in his home with his three sons, his daughter and lovely wife, sitting before a crackling fire after a meal that warms the heart as well as filling the stomach."

Dr. Ayoub, a native of Palestine, was educated at the American University of Beirut and the University of Minnesota before coming to UF in 1969, where he specializes in the research and treatment of streptococcal infections and rheumatic heart disease.

The Hippocratic Award was established by the medical class of 1969 and over the years has come to be regarded as one of the most coveted teaching awards in UF's College of Medicine.

Duval County Medical Society Executive Vice President dies

Ernest R. Currie, Executive Vice President of the Duval County Medical Society, and President and General Manager of Medi-Phone Bureau, Inc., recognized as one of the leading medical society executives in the United States, died May 14, 1984, at Baptist Medical Center in Jacksonville, Florida, after a brief illness.

Born on August 5, 1922, he was one of three children of the late Mr. and Mrs. John J. Currie. He was born in Cleveland, Ohio, and reared in Clearwater, Florida. He had been a resident of Jacksonville for over sixteen years.

In addition to his position at Duval County Medical Society, Currie was the Chief Executive Officer for the Jacksonville Area Foundation for Medical Care and the Academy of Medicine, Jacksonville, Florida. He was the Executive Agent for the Jacksonville Area Physicians for Better Government and Founding Executive of Jacksonville Area Professional Standards Review Organization. He was a member of the American Association of Medical Society Executives, American Society of Association Executives, American Association of Foundations for Medical Care, the American Medical Association (Affiliate Member), Florida Conference of Medical Society Executives (of which he was Chairman at the time of his death) and Florida Society of Association Executives.

Raised in the Methodist Church, he was a charter member of the Lakewood United Methodist Church, Jacksonville, Florida, and was active in various church activities until his death.

He earned his Bachelor of Arts Degree from the University of Florida in 1949, and completed the Institute for Organization Management Program at Michigan State University in 1970. Throughout his

career he was active in various programs of study in continuing education for association and medical society management.

Known throughout the health care community as a leader, he had earned the reputation among his peers as an innovator and a visionary. His accomplishments were many — one of the most recent was his work in developing the comprehensive prepaid health care plan sponsored by the Duval County Medical Society and operated as a program of the Society's Foundation for Medical Care.

He was a member of the Rotary Club of Jacksonville and held a variety of offices within the organization. He was also a member of the Executive Committee, North Florida Council Boy Scouts of America, in which he was very active. He was an active participator in the United Way of Jacksonville and he was a member of the Committee of 100, Jacksonville Area Chamber of Commerce. He was also a member of the St. Johns Dinner Club.

He is survived by his wife, Pauline Janes Currie; his sons Michael Richardson, Jonathan Janes and Brian Ernest Currie; four grandchildren; a sister, Mrs. Stephanie Farley of Clearwater, Florida, and a brother, Newton Currie of St. Petersburg, Florida.

A memorial service of Mr. Currie was held on May 17 at Lakewood United Methodist Church in Jacksonville.

In lieu of flowers, the family has requested donations to either the North Florida Council Boy Scouts of America, or to WJCT-FM, Stereo 90, Jacksonville.

Dr. Donegan appointed to National Advisory Council on Aging

Health and Human Services Secretary Margaret M. Heckler has announced the appointment of Charles K. Donegan, M.D. to the National Advisory Council on Aging.

Dr. Donegan, a cardiologist at the St. Petersburg Medical Clinic and Clinical Professor of Internal Medicine at the University of South Florida College of Medicine in Tampa, has more than 35 years of experience in the health care of the elderly. He has served as president of the American Society of Internal Medicine and as governor of the American College of Physicians for the State of Florida. He is a member of the Board of Governors of the Florida Medical Association and is chairman of the Florida delegation to the American Medical Association House of Delegates.

Dr. Donegan's awards include the Presidential Service Award of the Pinellas County Medical Society and Presidential Recognition for Outstanding Contribution to the University of Florida. He also received the Gold Service Medallion for ten years service on the Board of Governors of the Florida Heart Association. Also, the Sun Coast Chapter of the American Heart Association has established the Charles K. Donegan Career Investigator Award at the University of South Florida College of Medicine for outstanding career investigators in cardiovascular research.

The National Advisory Council on Aging meets three times a year to review applications for support of research and training projects relevant to the mission of the National Institute on Aging (NIA). The council also advises the Secretary of DHHS and the directors of the NIA and the National Institutes of Health on research and other programs on aging.

FMA holdings now complete

The library at the University of West Florida now has Florida Medical Association publications from the FMA Proceedings beginning in 1884 to the present. Microfilm was obtained through the FMA and Historical Editor, William M. Straight, M.D., of Miami from the beginnings of the FMA Proceedings in 1884 and copies of *The Journal of the Florida Medical Association, Inc.* from its inception in 1914 up the the 1920's. Mr. James A. Servies, Director of Libraries for UWF recognized the need to complete the gaps. The University of West Florida has been a subscriber to *The Journal* since the beginning of the University in the mid 1960s. Microfilm for the intervening years has been obtained. The Auxiliary supported the initial effort and for the latest acquisitions, the Auxiliary and the Escambia County Medical Society each contributed approximately one hundred and fifty dollars. The library is now probably the only one in the state with a virtually complete file of these rare publications.

DEAN'S MESSAGE

Reflections on this year's medical school graduation

On May 4, 1984, University of Miami President, Edward T. Foote, II, presided over the official 1984 convocation for the award of Baccalaureate, Masters, Doctoral and Professional Degrees. It was the third University-wide graduation held on the Coral Gables campus and reaffirmed the true collegiality of our Institution.

Two days later, the School of Medicine honored its graduates with another ceremony at which time the new physicians received their Diplomas and took

the sacred Oath of our noble profession. Traditionally, the President of the University has officiated at the School's commencement, but this year he suggested that the ceremony be conducted by the Dean. He felt this would be more appropriate because of the intimate and special nature of our ceremony.

I would like to describe briefly my observations about our graduates, the meaning of the commencement address and my reflections about the ceremony and what it symbolizes.

The Graduates: Never has our profession faced so many challenges. Many fear that the "Art of Medicine" has been lost; that today's graduates, although extremely well-trained in science and technology, have lost their perspective of human values and the meaning of the term, "Physician". As I looked over the sea of faces representing our 28th graduating class, I knew these concerns were unwarranted. Although I speak with bias and solely about our own students, I am extraordinarily optimistic about our profession and its future. During the past four years these students have made a meaningful contribution not only to improve our school but toward society in general.

In a world of DRGs, economic grand rounds, controversies with the federal government about equitable support for medical education, trying to persuade our society that it is unconscionable that only two percent of our nation's health care budget is allocated for biomedical research; extremely complex ethical issues, and yes — parking, it is comforting to know that our students can deal with these issues with equanimity.

Students make it a pleasure to come to the UM-Jackson Medical Center. Their bright faces, friendly "good morning," and constructive recommendations on how to improve the system constantly recharge one's batteries. Their suggestions are not for themselves but for classes to follow. To be more specific, the students have established a Code of Ethics more far reaching than a simple honor code. Their code is concerned with patient's rights and physicians' attitudes and responsibilities, the need for continuing medical education to insure the practice of good medicine, and a wide range of very complex and sensitive ethical issues. They want to know the cost of x-rays, pharmaceuticals and laboratory work being ordered. They question the reasons for hospital and physician cost inefficiences. They are concerned about the limited resources necessary to care for the massive population of patients we serve at the UM-JMH Medical Center. They insist that such matters be discussed, and when appropriate, to become part of the curriculum.

I am gratified and amused when President Foote visits the School of Medicine and asks student leaders at lunch to tell "What's the Dean doing wrong?" The response is a litany of positive things that they are doing to help others: Career Day Programs for minority students in the local high schools; the Big Pine Key Project to help the elderly in Monroe County; their own contribution $50,000 to student scholarships; a day dedicated to Medical Ethics with invited speakers from all over the nation; positive suggestions on how to refine an already strong curriculum; a musical show to raise funds for the Ronald McDonald House; methods of establishing tradition; on and on it goes.

You learn even more about these people of the future by reading their wonderful yearbook, Synapse, and attending their Senior Class Dinner dance. The majority of students use their personal section of the volume to thank parents, spouses and friends. The relationships they have established in medical school are permanent because they are caring people. The Art of Medicine is not lost. The graduates are armed with a great deal of basic science and clinical information; they are sensitive, warm compassionate people. To emphasize the point, let me explain the students' criteria for the selection of an individual to give the commencement address. They want a speaker to talk about their responsibilities as physicians, and this year a better choice could not have been made than Dr. Norman Kenyon, a distinguished graduate of our School's first Medical School class and a professional well-respected by this academic community.

The Commencement Address: Medical students should select their own commencement speakers. With all due respect to theatrical, political, business dignitaries, etc., they simply cannot offer the right message at a time when students and their guests want to be stirred — to be reminded about where they have been and what is ahead. Medical school graduation marks the culmination of nearly a quarter of a century of education and it is only the beginning. To me, it is second only to the first day of medical school when the anxiety level is high and student idealism is at its apex. The commencement address must rekindle individual dedication and commitment. In order to accomplish that important objective, the speaker must feel it. Dr. Kenyon gave the graduates and the audience what they wanted and needed. He reminded everyone of what it meant to join the ranks of those in the healing arts who have the responsibility of the health of our nation and the world. Of equal importance, he symbolized the success of our School and any school's most important product — its students!

Dr. William J. Harrington, Distinguished Professor of Medicine and father of a graduating student was given the special honor of introducing each graduate individually. My own feeling was that of intense pride not only for each member of the class

and their families but for our School. As the students proceeded across the stage, I discerned a mixture of feelings in all of them. They were at once proud, happy, relieved, and, paradoxically as in the beginning, anxious and insecure about the new responsibilities that they would be starting in a few weeks. Some had tears in their eyes, many palms were sweaty, but in one way or another, each of them for a moment said "thank you — it's been tough, but it was worth it."

The Ceremony and its meaning: After the individual recognitions, the Oath was administered by Dr. Fred Schild, President-elect of the Dade County Medical Association. There is no way to describe the expressions on the faces of the graduates standing before us. For ten years, I have had the opportunity to observe those faces and I am convinced that this particular moment may be one of the most important in the career of any professional. Whether the Oath be that of Hippocrates or Maimonides, it represents Medicine's tradition and the graduates know it.

Then the graduating class' last request — the opportunity to rise and express their personal appreciation to family and friends. Each year the standing ovation given by the new physicians is louder and longer. The noblest of professions will be well-served with young men and women such as these going out to practice Medicine. The faculty and staff of our School of Medicine and our teaching hospitals are proud to be a part of such a great tradition.

The psychologist, Ernest Becker, writes that "Society . . . is a vehicle for earthly heroism . . . Man transcends death by finding meaning for his life . . . It is the burning desire for the creature to count . . . What man really fears is not so much extinction but extinction with insignificance . . . Ritual is the technique for giving life!" It is appropriate that the ritual of medical school graduation symbolizes the meaning of our profession.

Editor's Note: Dr. Norman Kenyon's Commencement Address is in this issue as a Special Article on page 411.

Bernard J. Fogel, M.D.
Vice President for
Medical Affairs
and Dean
University of Miami
School of Medicine.

WORTH REPEATING

Hospitals offer more perks

The latest news from the medical world is that hospitals are having more difficulty attracting patients. Occupancy rates are down and many institutions are now resorting to advertising and hiring marketing people to get people to use their beds.

The competition is getting fierce, and no one can predict what kind of perks a hospital will offer to get a patient to use one of its rooms.

I visited a marketing consultant who works for one of the major hospitals in the Washington area. He was very excited about a new idea he had just come up with.

"What do you think of an 'Operation of the Month Club'?" he asked me.

"It sounds good," I told him. "What do you get if you join?"

He showed a full-page layout he had designed. Bannered on the top: "SAVE ONE THOUSAND DOLLARS ON EVERY OPERATION. Join the Operation of the Month Club." Then there were photographs of different parts of the body and large type: "WHEN YOU JOIN YOU ARE ENTITLED TO ANY ONE OF THESE OPERATIONS FREE." Then in smaller type: "All you have to do is have four operations a year, and you will be entitled to another AT NO COST TO YOU."

"Wow," I said, "that's really a buy. How does it work?"

"Every month we will have a distinguished panel of surgeons choose the 'Operation of the Month,'" he said. "Let's say the main selection for April would be an appendectomy. You would get a notice in the mail that it is being offered. If you don't return the card within ten days, we'll send an ambulance to your house and whisk you off to the hospital and perform the operation for one-half of what it would cost if you just went in and asked for one."

"Suppose I don't want an appendectomy?"

"Then you will have the choice of 30 alternate selections, anything from a tonsillectomy to implanting a pacemaker, at the same low prices. And remember you only have to choose four a year, and you get a free one as a bonus."

"What an ingenious marketing plan. I know as a member of the 'Book of the Month Club,' I always forget to send the card back and I'm stuck with the main selection. I'll bet the same thing happens with the 'Operation of the Month Club.' Will major medical pay for my membership?"

"I'm working on that now," he told me. "The savings from our operations as a club member should be very attractive to all the medical plans."

"How do the doctors feel about it?"

"Most of them are very excited, because they'll get a large advance. For example if an artifical hip is chosen 'Operation of the Month' the hip specialists stand to make a fortune, particularly if the surgery becomes a best seller."

My friend showed me the mockup of the "Operation of the Month News Bulletin."

"When you become a member you'll receive 15 issues of this beautiful colored, illustrated magazine outlining the various operations the hospital performs and biographical information on the surgeons who perform them. We'll also have reviews by medical critics of the various surgeons' techniques.

"Here's one on Dr. Paramedic, reviewing his skill at removing gallstones."

My friend read it to me. "Doctor Paramedic has performed 2,000 gallstone operations in his time. Once he gets a scalpel in his hand he can't put it down. Fast paced, and riveting, a Paramedic gallstone opeation is a must for someone who is looking for an exciting operation, with no pain. The New York Times says, 'When it comes to gallstones, Paramedic is in a class by himself.'"

"You've got this all thought out," I said admiringly. "If the 'Operation of the Month Club' catches on, hospitals will never have to worry about filling their beds again."

He seemed pleased with my reaction. "I'll tell you what. If you sign up as the first member, I'll arrange a hernia operation for you for nothing."

"But I don't need a hernia operation," I told him.

"Then choose one of the alternates. It's all the same to us."

Art Buchwald
Los Angeles Times Syndicate

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Competition and prospective pricing in medicine: Where do they lead?

A recent article in *Nation's Business* (November 1983, p22) raised a question regarding the Reagan administration's long-range program for dealing with soaring medical costs: "Will the administration follow through on its promise to help develop a health care system based on cost-cutting competition, or will it concentrate on lowering its own health care bill by transferring costs to the private sector?" How the federal government answers that question and develops a health care policy for the 1980s is of great interest and concern to several groups: the purchasers of health care (business and industry, unions insurance companies, and the various levels of government), the providers of health care (physicians, hospitals, clinics, and other health professionals), and the consumers of health care (the general public). Although it has become increasingly evident that the era of unlimited dollars for health care has ended, the why and how of increased competition, as well as whether it will be beneficial, are still unanswered.

To approach an answer, let us first look at the past. In 1978, expenditures for health care totaled $192 billion. Today total health care costs exceed $280 billion annually and are expected to reach $500 billion by 1986. In 1978, more than 85% of the sum was spent on personal health services, with the bulk going to pay for hospital services. That has not always been the case. Before 1939 physician services were the largest single item of health care expenditures, 28% for physicians and 18% for hospitals.[1] Since World War II, hospital expenses consume 40% of health care expenditures and physicians' services only 20%.[1]

This shift in dollar allocation has been accompanied by an increasing demand for health care by all segments of our society. High demand, coupled with relatively easy accessibility, has resulted in rapidly increasing costs. Therefore, throughout the 1960s, 1970s, and until now in the 1980s, the federal government has instituted more and more controls. Society now awaits the administration's plan(s) to restructure the health care delivery system and the reimbursement system through competition. The posture seems to be deregulation, because the regulatory approach simply has not worked. This shift, although viewed by Washington policy-makers and legislators as an opportunity to reduce the rapid increase in costs, is far from a panacea. Dismantling a regulatory system that has grown up over 20 years contains many problems, as exemplified by the deregulation of the airline industry. The implications of health care deregulation are even more serious because deregulation is not necessarily accompanied by any shift in demand or reduction in service.

Although we believe that major reforms in the industry should come from the providers, the reforms may come from the consumers instead. Speaking before a meeting of the American Marketing Association, Ron Osborne, Vice-President for Health Services Research of Blue Cross/Blue Shield, stated that patients and employers, rather than physicians, will be making the choices that will bring

major reforms. Mr. Osborne is quoted as saying that some of the key problems insurers have found are admissions for doubtful reasons, one- and two-day surgical stays, variations in average length of stay by diagnosis, and use of tertiary care institutions for primary care.[2]

The purchasers of health care are therefore becoming more selective in choosing their options. The federal government, one of the major health care purchasers through Medicare and Medicaid, has shifted from cost-per-case limits to a prospective pricing system based on "diagnosis related groups" (DRGs). That system assumes an equivalent length of stay for any medically similar illness, and reimbursement is targeted toward a single predetermined amount.

Health maintenance organizations (HMOs) are now widespread across the country and have reached a high level of financial sophistication, many moving from a nonprofit to a profit-making status. The number of plans and their composite membership continue to increase. Projections for the next decade indicate a potential doubling of the current enrollment.

Preferred provider organizations (PPOs) are another example. In this type of organization a group of physicians, a hospital, or a hospital and its medical staff agree to provide care to a certain group of individuals at a negotiated fee — often at a discount of 15% to 20%.[3] The Federal Trade Commission has given tentative sanction to one type of PPO, and almost 100 such arrangements are now operating in different configurations in this country.

The common denominator in all these plans is prospective pricing, which might be termed "regulated deregulation," and the movement to prospective pricing could be swift. Mervin Sholowitz, M.D., an internist and health consultant, is quoted as saying, "By 1990 some form of contract care will replace some 40% of fee-for-service income. The doctors who don't get this business will go out of business."[3]

In the past, government cost ceilings have resulted in cost shifting from government programs to other third-party payers, including private insurance programs and Blue Cross, as well as private patients paying their own bills. The philosophy now is to end the possibility of cost shifting and to implement instead ". . . a comprehensive, all payers, capitated payment system for health care."[4] These words were spoken by Republican Senator David Durenberger of Minnesota at a recent conference on hospital-medical public issues. He further warned: "We saved Social Security by sending the bill to young people. We will not do that for Medicare. I predict that we will send the bill to the hospitals and physicians of the United States."[4]

As the projected competition becomes better organized and more efficient, and the incentives are being appreciated by the appropriate targeted group, there will be a continuing decrease in use of hospitals. Some hospitals may close; others will attempt to improve their cash flow from revenue other than that generated by inpatients. Expansion of hospital services calls for a greater interplay among hospital administrators and boards, physicians, and the civic and business leaders within the community served by the hospital.

Another cost reform now before Congress would establish a ceiling on tax-free health insurance benefits. This concept would limit the high-priced health plans and would tend to equalize the tax-free insurance programs by eliminating first-dollar coverage and/or extremely comprehensive coverage. Economically, this proposal tends to balance the advantages of a wage increase to workers with those of added health benefits.

Many of these models, in addition to offering health care at a discount, also are viewed as having the potential to reduce overuse of both hospitals and expensive technical procedures. With this prospect goes the fear of lowered quality of care. According to a recent report released by Congress' Office of Technology Assessment, proposals to inject more competitive forces into the health care marketplace ". . . raise concerns about the resulting quality of care."[5] Increased competition could result in ". . . less than adequate quality of care because physicians and hospitals would have financial incentives to limit costs, even at the expense of quality."[5]

The government's answer to concerns about quality of care is that the process of peer review will assure quality. Even though the Reagan administration and influential members of Congress have opposed continuation of the professional review organizations (PROs), it was recently reported that the program was funded for $13 million in fiscal year 1984.[6] It is questionable whether PROs can be depended upon to assure quality, and some authorities believe that ". . . the overall approach being taken to implement the PRO program today will prove unworkable in the long run."[6] The attempt to control cost and quality appears to be a double-edged sword.

In the rapidly changing climate of "regulated deregulation," practicing physicians must attempt to integrate a fragmented health care system so that the services they provide are effective in terms of quality and cost to their patients. Physicians must continue to promote the principles of high-quality care, at the same time being constantly aware of the economic limits of society and of their individual patients.

Certainly the changing high technology, automated procedures, and competitive philosophy are

placing great demands on the ability of physicians to deliver high-quality care and the close personal attention that patients want. The thrust is toward diagnosis and treatment ". . . outside the high cost of acute care hospitals. . .in regional centers with integrated systems of communication networks, linking the multitude of medical practitioners."[7] Yet medical care is still a very personal and individual need. Physicians, while still the center of the system, must recognize the forces at work requiring change. Physicians will be pressured to effect changes, while they will, in fact, be simultaneously forced to change themselves. Physicians can still be a major influence on health care policy and medical care management, but they must increase their awareness and knowledge of the forces of change and concentrate their attention on formulating the policies, programs, and structure for a more integrated and cost-effective health care system.

References

1. Goldsmith, S.B.: An Overview of the U.S. Health System. Health Care Management. A Contemporary Perspective. Rockville, MD, Aspen Publications, 1981, pp 17-26.
2. Consumers Drive Health Reform. Hospitals, May 1, 1983, pp 17-18.
3. Cassidy, R.: Will the PPO Movement Freeze You Out? Med. Econ., April 18, 1983, pp 262-274.
4. Friedman, E.: Prospective Pricing Only First Step. Hospitals, May 16, 1983, p17.
5. Cost Sharing May Jeopardize Care. Hospitals, Feb. 1, 1983, p62.
6. AHA, HCFA Negotiate Peer Review Program, Hospitals, Nov. 16, 1983, p28.
7. Jobe, W.E.: Presidential Address. Read before the meeting of the American College of Radiology, Boston, MA, Sept. 20, 1982.

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INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussions of medical history and ethics; and articles dealing with socioeconomic, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to Daniel B. Nunn, M.D., Editor of *The Journal*, Florida Medical Association, Post Office Box 2411, Jacksonville, Florida 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

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BOOK REVIEWS

Book Review Editor — **F. Norman Vickers, M.D.**

Medical casebook of Doctor Arthur Conan Doyle

By Alvin E. Rodin and Jack D. Key, 500 Pages. Price $28.50. Krieger, Melabar, Florida, 1984.

The origin of this book is almost as interesting as its contents. Two authors met through the Oslerian Society and discovered another mutual interest, that of Arthur Conan Doyle. Rodin is Professor and Chairman of the Department of Postgraduate Medicine at Wright State University, Dayton, Ohio and Jack Key is Associate Professor of Biomedical Communications, Mayo Medical School and Librarian of the Mayo Foundation.

The book traces Doyle's early life, his medical education, and correlates his writings with his medical activities and other events in his life. As the son of a minor government official, Doyle grew up in Edinburgh a few blocks from the medical school from which he graduated in 1881. Dr. Joseph Bell was one of Doyle's preceptors. It is thought that Bell's characteristics of minute observation form the model for Doyle's Sherlock Holmes.

The authors put to rest the myth that Doyle was a failure at practice. He settled at Southsea and practiced there eight years. After a brief visit to Berlin in order to hear Robert Koch, Doyle went to Vienna to study ophthalmology. He then returned to London and had an office opened for practice of ophthalmology for only a month. The authors feel that his "so-called failure as specialist in ophthalmology was really due to lack of motivation." Doyle's knighthood related in part to his service to Britian during the Boer War, his subsequent publication of several works including *The Great Boer War* within two months of his return. "This was a remarkable achievement encompassing a 552 page detailed account of enumerable battles and related politics."

Doyle was writing for publication during his Southsea of general practice. This process accelerated to a degree that it left little time for him to see patients.

A large portion of the book, of course, deals with Sherlock Holmes, physicians, medicines, diseases and surgery contained in these stories.

The book is written for a general audience. However, the physician with even a casual interest in Doyle and Sherlock Holmes will find the book facinating.

F. Norman Vickers, M.D.
Pensacola

● Dr. Vickers is an Associate Editor and Book Review Editor of *The Journal.*



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Auxiliary Liaison Editor -- **Mrs. Walter (Isabella) Laude**

Auxiliary in action

Lights, camera, action

With more than thirty-three different programs throughout the state, the Auxiliary is one of the most active organizations in existence today. Over five thousand physicians' spouses are actively working to carry our message to the public: "Better Health for the People of Florida."

Last year as President-Elect, I was privileged to visit all six districts of our state. What a learning experience it was! I saw every county auxiliary involved in a broad scope of programs. I was impressed by the variety of approaches, the diversity of projects, and the commitment of auxilians to our common goal for improving the quality of life for all.

After this experience it became obvious to me that by using the theme, "Auxiliary in Action" for the year 1984-1985, we could truly emphasize the many wonderful projects in action right now. Although we will be searching for more innovative approaches to upgrade and streamline our projects, my goal is to encourage those already working so hard.

Special emphasis will be placed on health education and public relations: letting the public know who we are, what we do, and why. Programs particularly for children will include our comic strip, "The Hasty Family," to help spread health and safety tips to children everywhere. We have also begun a statewide effort to help set the standards for television aimed at children.

Legislative issues are of concern to all of us, and we will continue to educate and stimulate all auxilians to participate and work with our legislative committee.

The Board of Governors of the Florida Medical Association has asked for our assistance with a public relations program "to educate the community and physicians in the support services that are available for citizens, including the elderly, and to promote the concept of family health care for senior citizens." This, we pledge to do, and will be working on a combined slide-audio production to be presented to civic meetings, clubs, county medical societies, local hospitals, and nursing homes. Local radio talk shows will be requested to feature home health care for the elderly. Auxilians will encourage local participation in these programs among physicians.

Lights, camera, action: The Fall Conference for Auxilians will feature the plans for an "Auxiliary in Action." To be held at beautiful Sandpiper Bay, Port St. Lucie, September 18-20, 1984, "Take One" will feature an orientation on the federation of local, state, and national auxiliaries by the secretary of the AMA Auxiliary, Mrs. Mylie E. Durham, Jr. "Take Two" will see Auxilians sharing concerns and solutions, with seminars on legislation, programs, public relations, and fundraising. "Take Three" highlights a session on "Assertive Leadership and Communication" led by Marie Zeller.

Lights, camera, action: The Auxiliary is ready for the year ahead, and auxilians will be converging at Fall Conference to begin the first step toward a realization of its goal for "Better Health for the People of Florida." I am looking forward to working with the President of FMA, Dr. Frank C. Coleman and the FMA. I ask all Auxilians to join us at Fall Conference, and to participate in our programs as we continue to strive to be an "Auxiliary in Action."

Mrs Laurin G. (Nancy) Smith
FMA Auxiliary President 1984-85

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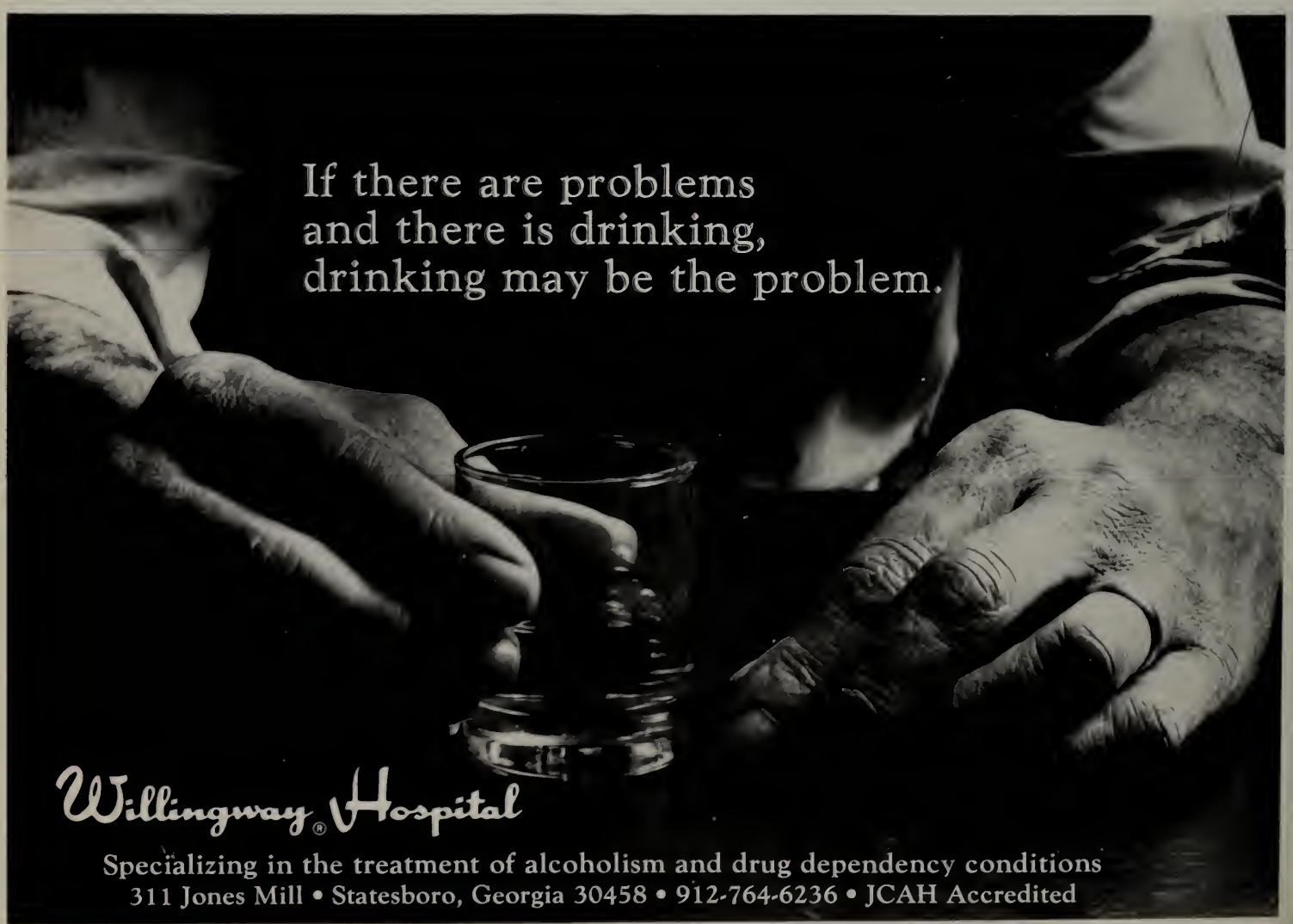
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FMF IMPAIRED PHYSICIANS COMMITTEE NEWSLETTER

Published by the Committee on Impaired Physicians / Florida Medical Foundation / P. O. Box 2411 / Jacksonville, Florida 32203

July 1984 "Doctors Helping Doctors" Vol. 1 — No. 3

Dr. Macdonald Named ADAMHA Administrator

Donald I. Macdonald, M.D., of Clearwater, Chairman of the FMA Committee on Substance Abuse, has assumed duties as Administrator of the federal Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) in Washington.



Dr. Macdonald

On April 6, the White House announced President Reagan's nomination of the Pinellas County pediatrician to succeed Dr. William Mayer, subject to Senate confirmation.

In recent years Dr. Macdonald has been a frequent lecturer on drug problems and is the author of a book entitled "Drugs, Driving and Adolescence".

AMA IP Conference Set for September 6-9

The American Medical Association's 6th National Conference on the Impaired Physicians will be conducted at the Middlelands Hilton Hotel in Secaucus, N.J., September 6-9, 1984. Secaucus is located near New York City and Newark, N.J.

Physicians attending the meeting may earn AMA Category I CME Credit on an hour-for-hour basis.

Registration fees include: AMA members, $125; non-member physicians, $185; AMA member house staff, $65; non-member house staff, $125; non-member medical students $35; and all others, $125, except for AMA student members and physicians spouses, for whom there will be no charge.

Further information may be obtained by contacting Mrs. Janice Robertson, Health and Human Behavior Program, American Medical Association, 535 North Dearborn Street, Chicago, IL 60610.

President Announces Appointments to Committee on Impaired Physicians

The reappointment of Chairman Guy T. Selander, M.D., and the appointment of two new members to the Committee on Impaired Physicans were announced recently by FMA President Frank C. Coleman, M.D., of Tampa.

New additions to the Committee are Nelita R. Ano, M.D., a South Daytona child psychiatrist; and Laurin G. Smith, M.D., a family physician in Vero Beach. Dr. Coleman also reappointed several incumbent members of the Committee, including two who had been appointed last March by FMA Past President J. Lee Dockery, M.D. They are Harold L. Ishler Jr., M.D., of Clearwater, and John E. Perchalski, M.D., of Tampa.

A native of the Philippines, Dr. Ano received her M.D. degree in 1962 from the College of Medicine of Cebu Institute of Technology there, and completed a residency and fellowship in general psychiatry and child and adolescent psychiatry at the University of Florida. She has served as Chairman of the Impaired Physicians Committee of the Volusia County Medical Society.

Dr. Smith, a North Carolina native, received a B.S. degree in pharmacy from the University of Florida in 1964, and graduated from the University of Miami School of Medicine in 1970. His wife, Nancy, is the current President of the Florida Medical Association Auxiliary.

Both Dr. Perchalski and Dr. Ishler are originally from Pennsylvania. Dr. Perchalski is a graduate of the University of Florida College of Medicine and completed internship and residency at Baptist Memorial Hosptial in Memphis, Tenn. Dr. Ishler is a 1967 graduate of Jefferson Medical College in Philadelphia, and completed a family practice residency at Akron (Ohio) City Hospital.

Dr. Selander is serving his fifth term as Chairman. He is a Past President of the Duval County Medical Society and the Florida Academy of Family Physicians, and at the FMA Annual Meeting last May, he was elected Vice Speaker of the FMA House of Delegates.

Rounding out the Committee for 1984-85 will be: Arvey I. Rogers, M.D., of Miami; John M. Butcher, M.D., of Sarasota; Hector R. Mendez, M.D., of Orlando; John F. Mason Jr., M.D., of Panama City; Mrs. B. David Epstein, of Key Biscayne, FMA Auxiliary Representative; and Dolores A. Morgan, M.D., of Miami, and George S. Palmer, M.D., of Tallahassee, both ex officio members.

Palm Beach Internist Heads AMSA Chapter

E. Joan Barice, M.D., a Palm Beach Gardens internist, was elected Chairman of the Florida Chapter of the American Medical Society on Alcoholism (AMSA) at its organizational meeting on May 3.



Dr. Barice

Other officers elected unanimously include: John C. Eustace, M.D., Miami, Vice Chairman; David Myers, M.D., Tampa, Secretary-Treasurer; and Dolores A. Morgan, M.D., Miami, and Lynn R. Hankes, M.D., Lakeland, members of the Executive Committee.

The Chapter also adopted the secondary name of the Florida Society for Addictive Diseases to reflect its broad interest in chemical addiction. Application will be made to the FMA Council on Specialty Medicine for FMA specialty group recognition.

According to Dr. Barice the AMSA nationally has about 1,500 members, including some 50 in Florida.

The organizational meeting was held in conjunction with the FMA Annual

(Continued on Next Page)

Palm Beach (Con't)

Meeting at Lake Buena Vista, and the group plans to continue having its annual business meetings at the time of the FMA convention.

Information about the state chapter may be obtained by contacting: E. Joan Barice, M.D., The Gardens Professional Building, 3400 Burns Road, Suite B, Palm Beach Gardens, FL 33410.

Palm Beach Institute Program Reapproved

The Committee on Impaired Physicians, at its meeting on March 30, reaccredited the Palm Beach Institute and affiliated facilities as treatment centers for impaired physicians. The approval, for a two-year period ending May 6, 1986, followed a Committee site visit to the main facility in West Palm Beach on March 3.

The approval also covers the PBI Hospital Program at Jupiter and the Friary on Pensacola Bay, but not the facility at Naples, which has not provided treatment for the required minimum of four years.

Two County Societies Name IP Committees

Since the last issue of the *Newsletter,* two more county medical societies — Franklin-Gulf and Walton — have organized local impaired physicians committees.

They bring to 28 the number of such local committees in existence.

Local committees are vital to the success of the overall statewide impaired physicians program, according to Guy T. Selander, M.D., Chairman of the FMF Committee on Impaired Physicians.

Such committees are extremely helpful in casefinding, intervention and aftercare monitoring, he said. All FMA county medical societies are strongly urged to have such a committee.

AMA Committee

Donald M. Keith, M.D., of Seattle, Wash., has been named to head a committee of the American Medical Association that will evaluate current AMA policy, goals and activities in the impaired physician area.

Prescription Drug Abuse Conference Planned for October 15-16 in Tampa

A statewide conference on prescription drug abuse is being planned for October 15-16 in the Tampa area.

Primary sponsor of the meeting will be the Florida Prescription Abuse Data Synthesis (PADS) Project, in which the Florida Medical Association and several other private and government organizations and agencies are participants.

Pierre J. Bouis Jr., M.D., of Tampa, Associate Dean for Continuing Medical Education at the University of South Florida College of Medicine and Chairman of the FMA Council on Scientific Activities, and Mr. Frank D. Nelson of the HRS Drug Abuse Program in Tallahassee are planning coordinators.

Purpose of the conference will be to educate health care professionals as to the extent of prescription misuse, abuse and diversion in Florida and as to how they can impact on this growing problem.

Additional information may be obtained by contacting: Mr. Frank D. Nelson, Administrator, HRS Drug Abuse Program, 1317 Winewood Blvd., Tallahassee, FL 32301.

New State Commission to Focus on Prevention and Education Issues

Drug and alcohol prevention and education have been assigned top priority on the agenda of the new Florida Commission on Drug and Alcohol Concerns.

At the second meeting of the newly-formed Commission on May 24, Chairman John Tucker of Jacksonville appointed four subcommittees and split the work among them. The first subcommittee will consider prevention and education issues.

Joseph H. Deatsch, M.D., of Jacksonville, an FMA representative on the Commission, was selected to chair a subcommittee which will examine issues related to treatment. Another subcommittee will look at the role of law enforcement in education and treatment. The fourth sub-group will study the roles of the media and industry, drunk driving policies, insurance concerns and other issues.

The Commission is expected to conduct public hearings before preparing and submitting a report to Governor Graham next year.

Hazelden Offers Training Program

The Hazelden Training and Professional Education Department in Center City, Minn., is offering an experimental chemical dependency program for physicians.

During separate but similar sessions during July 9-13 and October 8-12, doctors will experience the Hazelden multidisciplinary approach to treatment as a participant in one of the primary units. Structured training sessions will focus on the physician's role in diagnosis, intervention, referral, treatment and recovery.

Richard Heilman, M.D., Hazelden's senior consulting psychiatrist and Chief of the Drug Dependency Unit at the Minneapolis VA Center, will be principal instructor. A tuition fee of $500 includes meals but not lodging.

Additional information may be obtained by writing Hazelden Training and Professional Education, Box 11, Center City, Minn. 55012, telephone (612) 257-4010, Ext. 417.

Sick Doctor's Story Now at Bookstores

A first-person account of one physician's impairment and recovery is now available at bookstores throughout the country.

Dr. Patrick Reilly's autobiography, "A Private Practice", was published by McMillan and Company. Universal Pictures plans to make the book into a movie.

Reason '84 petition signature campaign moving toward successful conclusion



The petition signature phase of our Reason '84 Constitutional Initiative Campaign is coming to a close, and I am pleased to report to you that with one week to go in the petition drive, over 390,000 signatures have been obtained. Certainly, there is reason for cautious optimism that we will indeed be able to obtain the necessary 298,734 valid signatures required to have the FMA's tort reform proposal placed on the election ballot in November.

The people of Florida have responded positively and in large numbers to the campaign demonstrating their sincere concern and desire to do something about rising health care costs, a large part of which can be directly attributed to the increasing severity of the professional liability problem in our state. I am also extremely gratified by the physician community's response. First, by the tremendous response from the vast majority of FMA members who have paid the special 1984 assessment unanimously voted by the House of Delegates in January to help finance the campaign, and secondly, by the many FMA members who have actively worked in helping obtain signatures. I would also like to give special thanks to the FMA Auxiliary for their extraordinary efforts in helping with the signature petition drive.

I should point out that we do anticipate a court battle initiated by the Florida Academy of Trial Lawyers challenging our petition on the "one subject" issue, which was the argument used to nullify the citizens tax-relief amendment (Proposition One). However, we are optimistic that we will be able to successfully show that our amendment qualifies as one subject. It will then be our task to convince the voters of Florida to support the amendment at the polls in November.

The FMA did not embark on the Reason '84 campaign lightly. The Association has steadfastly held to its goal of bringing reason and justice back into a tort system in our state which has gone haywire. Since 1975 the Board of Governors, along with many dedicated physicians and other individuals, have made every effort to bring about tort reform through the legislative process that would resolve the professional liability crisis on a long-term basis. All of us know that this crisis, affecting each of us, our patients, and the general public, is worsening every day.

During the 1983 Session of the Florida Legislature, the FMA, at great expense in money, time and effort, sought the enactment of comprehensive tort reform legislation. However, even though we had the overwhelming support of the Florida Senate, the leadership of the House of Representatives refused to allow the FMA's tort reform proposals to be considered by the full House. Nothing happened.

Despite this legislative setback, the FMA House of Delegates at its meeting in May, 1983, directed the Board of Governors to continue to examine all alternatives for resolving the crisis in addition to the legislative process, including the constitutional initiative process. The FMA House of Delegates at a special Called Meeting on January 28, 1984, unanimously approved the FMA pursuing the constitutional initiative process in seeking to have tort reform placed on the November, 1984 General Election ballot. In addition, the House approved an

assessment of all FMA regular, active dues-paying members to help finance the initiative campaign.

As I have indicated, the people of Florida are responding very positively to our call for help in bringing about much needed tort reform in our state. A personal commitment by each of us to participate actively in the coming weeks of the campaign is essential if we are to be successful in November. As physicians we will be challenged to positively demonstrate to our patients, and to all citizens of Florida, that by resolving the professional liability crisis we can and will be able to cut health care costs, and we will continue to provide our patients with the very highest level of quality medical care.

Frank C. Coleman MD

EDITORIAL

The Medical Writer

The medical writer yearns to pass to others what his imagination creates and he does so through the medium of the written word. He needs the ability to see more than facts: to look beyond them; to hypotherize about them; to draw conclusions from them. The medical writer's criterion is never art for art's sake — always it is art for others' sake. He writes because he likes to — needs or has to write, there is no other valid reason. Just what is the nature of the need to write, precisely? The answer, put briefly, is this: all writers are persons who seek a larger world and when they find it, they pass it along to others.

A medical writer is driven by a need to escape the limits of a too-small world, the medical world, that is. It is in his blood to range farther than life can ever let him to. The impossible intrigues him. So do the unattainable, the forbidden, the disastrous. The medical writer wants to help guide the hand of fate, to somehow help mold the forces that shape the destiny of medicine.

Writing is not a logical process. Consistency is the hobgoblin of petty minds. The writer follows his feelings, sorts out the variables, rejects the false, catches glimpses of the larger pattern and draws confidences from knowledge. A good writer keeps grammar rules in proper perspective and violates them by design only. He will take sentence fragments, nonpunctuation, stream of consciousness and one-word paragraphs and make them tools for manipulation of his reader's emotions.

Feeling is very important to a writer. Feeling springs from the human heart. A writer seeks a reawakening, a heightened pulse and a richer awarness in his readers. Intellectualization of art is alien to a true writer's thinking. First, last and all the time the writer deals with what he feels. A medical writer is subjective more than objective, his inner world appears to be more important to him than the external one. A good writer must separate logic from emotion and critical judgement from creation. A writer knows that simplicity and brevity in the wrong place can destroy his work. He knows that the heart of any writing is vividness.

A medical writer uses his facts as stimuli to feeling. He emotionalizes the facts and gives them a unique private life. In writing more than almost any other field initiative is the key. Sensitivity, drive, facility with language all linked with knowledge are translated into a literary process.

To be a medical writer, a creative person must retain his ability to react uniquely. His feelings must remain his own. The day a medical writer mutes himself or moderates himself or represses his proneness to get excited or ecstatic or angry or emotionally involved — that day he dies as a writer.

Edward Pedrero Jr., M.D.
Tampa



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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.
JULY 1984 Vol. 71, No. 7

Historical Issue

In this issue. . .

This, the nineteenth Historical Issue of *The Journal of the Florida Medical Association*, begins with a previously unpublished manuscript on yellow fever written by the distinguished Cuban physician, author, poet and intellect, Dr. Thomas Romay Chacon, in 1804. This manuscript, which came to light about ten years ago, has been translated and edited by the distinguished professors of history, Dr. William S. Coker and Dr. John R. McNeill.

The second article describes medical care in Spanish West Florida and is the work of the distinguished retired Professor of History of the University of Alabama and Caballero in the Order of Isabel la Catolica, Sir Jack D.L. Holmes, Ph.D. The recognized authority on the Spanish period of the lower Mississippi Valley and the Gulf Coast, Sir Jack was knighted by Juan Carlos I for his many contributions to the understanding of Spain's dominion in North America.

The next two articles of this issue are by Dr. Rabun H. Williams of Eustis, Florida. Dr. Williams gives us his observations of medical care in the Golden Triangle of Central Florida and an account of the origin and development of the Waterman Medical Center.

The fifth article in this issue is by Dr. H.L. Harrell, of Ocala. Dr. Harrell records the medical history of Marion County during the past fifty years.

The final article deals with the medical beliefs and practices and the diseases of the Florida Indians who occupied our state before and during the first Spanish Period (1513-1763). This paper represents a vigorous two year search on the part of your Historical Editor in French, Spanish and English accounts and of the literature on Florida paleopathology and anthropology to assemble the scant information available.

We hope you find this issue both entertaining and informative.

William M. Straight, M.D.
Historical Editor

Dr. Tomas Romay's unpublished manuscript on yellow fever, June 27, 1804

William S. Coker, Ph.D. and John R. McNeill, Ph.D.

Dr. Tomas Romay Chacon (1764-1849) was a distinguished Cuban physician, author, poet and intellect. A cursory examination of the two volumes of his published works will convince even skeptics of his contributions in the field of medicine.[1] But he wrote on other subjects as well. About ten years ago, a manuscript written by Dr. Romay was discovered in the *Biblioteca Nacional* in Madrid.[2] A copy of the document was brought back to the United States, filed and forgotten. At the Tenth General Brown Conference at the University of Alabama last year (1983), the two of us, Professors Coker and McNeill, met for the first time. A discussion at one of the sessions turned to yellow fever and the Romay document became the subject of conversation. That talk resulted in the translation of the manuscript and its preparation for publication in this journal. The reasons for its publication will be made clear later in this introduction, but first more about Dr. Romay.

Tomas Jose Domingo Rafael del Rosario Romay Chacon was born in Havana on December 21, 1764. His paternal uncle, Fray Pedro de Santa Maria, supervised Tomas's early education. Tomas studied at the *Convento de Predicadores* and received his bachelor of arts degree in 1783. He obtained the master of arts degree in 1785. For several years Tomas seemed bent upon a teaching or legal career, but turned instead to the field of medicine. He undertook his medical studies at the Pontifical University of *San Jeronimo de la Havana*, where he acquired his bachelor of medicine degree in 1789. He passed his examination before the Royal Medical Board on September 12, 1791. Three months later Tomas was appointed Professor of Pathology, and on June 24, 1792, the University conferred upon him the degree of Doctor of Medicine.[3] He soon moved his classroom to the hospitals. There he promoted a new type of medical teaching and training; the study by observation of "the perceptible signs that the illness presents to us and the search to confirm the diagnosis in the practice of autopsies."[4] He also introduced the teaching and practice of public hygiene and is considered one of the first great hygienists in Cuba. In fact, Dr. Romay was more concerned with the problems of public hygiene than with private practice. Among other things, he urged an end to the practice of interring cadavers in the churches, and argued for the construction of a general cemetary. He disseminated the most advanced medical doctrine of his epoch by bringing to the attention of others the works of the foremost medical authorities of the 18th and early 19th centuries.[5]

A prolific author, Dr. Romay wrote in a number of fields. Although most of his published works pertained to medicine, he also wrote on agriculture, botany, chemistry, education, politics, and in a general category which can be labeled "literary" works.[6] In his earliest writings, published in 1792 and 1793, he used the pseudonym "Matias Moro," but the

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Fig. 1—Dr. Tomas Romay Chacon (1764-1849). Distinguished Cuban Physician. Photograph from Jose Lopez Sanchez, *Vida y Obra del Sabio Medico Habanero* (Havana: Editorial Libreria Selecta, 1950), following dedication page.

reason for doing so is not clear.[7] In all he published some 165 articles of which the greatest majority were on the subject of smallpox vaccination. Other medical topics included general medicine, hospitals, public hygiene, and fevers, including ten published articles and at least one unpublished manuscript on yellow fever.

Dr. Romay's reputation rests largely upon his long and successful fight on behalf of smallpox vaccination. Several articles written in this journal in 1977, one by Dr. Gilberto Cepero and the other by Dr. J. C. Gros, called attention to this aspect of his career. Dr. Cepero reported that Dr. Romay's introduction of smallpox vaccination in Havana provoked "an attack upon his home by a group of zealous anti-contagionists" which "resulted in the death of his wife."[8] Dr. Romay was so convinced that vaccination could prevent the dreaded smallpox that he innoculated his own children. But more! To prove his case he then injected them with the pus from the smallpox pustules of an infected victim. They did not get smallpox.[9] Dr. Romay's most recent biographer, Jose Lopez Sanchez, who was never sparing in his praise of Romay, wrote that the history of vaccination in Cuba during the first half of the 19th century is the history of a doctor: Tomas Romay.[10] Although no longer standing, the Romay Tuberculosis Hospital in the General Calixto Garcia Hospital complex at the University of Havana was named in his honor.[11]

Dr. Romay was also a member of Havana's burgeoning intellectual community and the scope and skill demonstrated in his writings clearly mark him as a man of the Enlightenment. As defined in Dr. Romay's case, enlightenment was a sincere desire to break away from superstition and to establish reason and the scientific method as the basis for his belief and conduct. Thus Dr. Romay, with the help of others, led the fight against scholasticism.[12]

Politically, Dr. Romay was a mixture of liberal and conservative thought and action. He favored a constitutional monarchy, but preferred that Cuba remain a Spanish colony. However, he did favor a municipal council, a *cabildo*, with some local autonomy. He served as Secretary of the Cuban Provincial Deputation following the establishment of the Spanish Constitution in 1812, but with the return of Ferdinand VII to Spain in 1814, the Constitution was discarded. After the Riego Revolt of 1820 which forced Ferdinand to reinstate the Constitution, Dr. Romay again served as Secretary of the Cuban Provincial Deputation. As such he became involved in a violent controversy with the *Peninsularies* (those born in Spain), some of whom opposed the Constitution. When the liberals were defeated in 1823 and Spain once again became an absolute monarchy, the Cuban Provincial Deputation ceased to exist and Dr. Romay's political activities also ended.[13]

While Dr. Romay's fame in the field of medicine derives primarily from his association with smallpox vaccination, our concern in this study is with his writings about yellow fever. No effort will be made to trace the history of this disease. That topic has already received considerable attention in previous issues of this journal.[14] It was the series of yellow fever epidemics along the Atlantic coast of the United States and in Cuba during the 1790's which piqued Dr. Romay's interest in the subject. Of all the diseases which periodically attacked Cuba, yellow fever was the most feared.[15] Following an outbreak of yellow fever in Havana in 1794, Dr. Romay was in charge of a ward in the *Hospital de Marina del Arsenal* where many of the ill were confined. There he had an excellent opportunity to study the disease and to form opinions about its course and treatment. He recorded his experiences and observations and in 1797 read a paper on the subject before a meeting in Havana of the Patriotic Society of the Friends of the Country. It was entitled, *A Dissertation about the*

Malignant Fever vulgarly called Black Vomit, an Epidemic Illness of the West Indies.[16] That some of his ideas missed the medical mark, such as the belief that yellow fever was contagious, and that bleeding of the victims was a good method of treatment, should not distract us from the significance of his treatise. After all, medicine was still in the age of trial and error. His paper is considered one of the best monographs on the subject of yellow fever written in that era. It produced an enthusiasm without precedence among those doctors who attended the lecture. They were stimulated by the lecture, and recommended that it be published without delay. Publication of Dr. Romay's paper in November of 1797 inaugurated medical scientific literature in Cuba. It also won for him appointment to the very prestigious *Academia Matritense* in Spain.[17]

Dr. Romay did not long remain convinced that yellow fever was contagious. Within two years, in July of 1799, he wrote a short article in which he questioned its contagiousness.[18] A year later he was even more convinced that it was not contagious.[19] He continued to observe and to read virtually everything printed on the subject in the next few years. During those years the disease took a terrible toll of lives. Yellow fever epidemics hit Spain several times in the early 1800's. In the attack of 1800 some 62,000 persons died, while in 1804 the casualties amounted to 53,000. Closer to Romay's home, however, was the island of Santo Domingo, better known today as Hispaniola. Hardly anyone would question the fact that yellow fever defeated the French army under General Victor E. Leclerc, which in 1802 attempted to return the western portion of that island to French control. Of 27,000 cases reported there in 1802, 20,000 of the victims died. In fact, the mortality rate among French troops throughout the West Indies in that year amounted to fifty-seven per cent. The island of Guadeloupe with a population of 16,363 reported 5,057 deaths from the disease in 1802.[20] Little wonder then that Dr. Romay showed such concern about yellow fever, and that he followed closely the writings of the French doctors.[21] In June of 1804, Dr. Romay wrote two articles on yellow fever. The first, published on June 14, 1804, pertained to the use of olive oil in the treatment of the illness, which Dr. Romay refuted advocating instead the use of tonics and stimulants.[22] The second article, written just two weeks later is the one with which we are primarily concerned in this paper. We are interested in this particular manuscript for several reasons.

Perhaps the first question which we should address is, why is this manuscript not included in the *Obras Completas*? First, it was never published as were most of the papers in the *Obras Completas*. Second, it is not as polished as many of his published papers, suggesting that it might have been a draft. Its discovery in the *Biblioteca Nacional* in Madrid may explain why it was not in his *Obras Completas*, which was published in Havana. The paper may have found its way into the *Biblioteca Nacional* through Dr. Romay's correspondence with members of the *Academia Matritense*. But that is only conjecture.

From the numerous papers written by Dr. Romay, it is obvious that he was intimately familiar with the writings of many of the foremost medical authorities, whether their studies were in Latin, English, French or Spanish. In the translated manuscript which follows, he referred to more than twenty such persons. We have not attempted to identify each of them, but, for the most part, they were all sufficiently prominent to be easily located in standard reference works. Identification of these physicians is not nearly as difficult as having access to their publications, all of which were printed prior to June of 1804. Even discovering where copies of their works are located is a herculean task.

Floridians might be interested in knowing that Dr. Romay included a reference in his manuscript to Dr. John Moultrie, Jr. (1729-1798). Among other positions, Dr. Moultrie served as lieutenant governor of British East Florida, and as acting governor of the colony, 1771-1774. We were fortunate to find an article by Dr. Joseph I. Waring concerning Dr. Moultrie in the August, 1977, issue of this journal. Moultrie's thesis, *De Febre Maligna Biliosa Americae*, presented to the University of Edinburgh in 1749 was published in Latin in 1768, and Dr. Romay was acquainted with it. Dr. Moultrie wrote from personal experience as well as from a medical point of view, because he had suffered from an attack of yellow fever in the epidemic which hit Charleston in 1745.[23] In addition to Dr. Moultrie, we also want to mention the three publications and their authors cited by Dr. Romay in his manuscript, and to say a few words about them and the other physicians which he referred to in connection with those publications.

In his first citation (a), Dr. Romay noted the *Nosographie philosophique* of Philippe Pinel (1745-1826). Dr. Pinel was a distinguished French physician, who taught medicine at the Salpetriere. The clinical lectures that he gave there formed the basis for his *Nosographie philosophique, ou la methode de l'analyse appliquee a la medecine*, first published as two volumes in one in Paris in 1797. In 1798, it appeared in two separate volumes. Pinel soon revised and expanded this study and, in 1802, volume one of the second edition was published. Then followed in 1803 volumes two and three. This work went through several subsequent revisions with the sixth edition appearing in 1818. Dr. Pinel's reputation in the medical field rests not upon yellow fever studies, but upon his introduction of humane treatment for the insane. He even removed with his

own hands the bond of patients who had been chained to the walls for years. Dr. Pinel authored studies other than the *Nosographie philosophique*, but, since that is the work cited by Dr. Romay, it is the one which we will discuss here.[24]

Dr. Romay referred to Pinel's statement that "yellow fever of the Americas begins in the form of *doneningo-gastrica*, moreover the symptoms which follow, and which Rouppe has described with such exactness, clearly identify the fever as of the fifth order — *ataxicas.*" Romay specifically cited the *Nosographie philosophique, tom. prem. f xxix.* That reference was not found in volume one of the 1802 edition, the only pre-1804 edition available to us. Volume one is a study of the six orders of fevers, and Pinel did refer to Dr. Ludovicus Rouppe in his discussion of the fifth order of fevers[25] Thus Pinel would have been familiar with Rouppe's dissertation, defended at Leyden in 1762, *Dissertatio practico-medica de morbis navigantum*, pertaining to diseases of seamen. This work was first published in Latin in 1764, and was later translated and published in English in 1772.[26] Perhaps someone who has access to Pinel's 1797-1798 editions may be able to confirm that Dr. Romay's reference is indeed there.

We are equally troubled with Dr. Romay's second and third references (b) and (c). In those he cited the works of Francois-Victor Bally, *Journal des officiers de sante de Saint-Domingue*, numbers 1 and 2. Bally (1775-1866) was a French surgeon, who had written his doctoral dissertation *La gangrene* at Montpellier in 1797. After medical service in Italy and Spain, Dr. Bally, as chief surgeon, accompanied General Leclerc on the ill-fated expedition to Santo Domingo in 1802. In addition to his *Journal*, Bally also wrote a memoir about yellow fever in 1803.[27] His subsequent interest and extensive writings about yellow fever undoubtedly stemmed from his unfortunate experiences with the disease on the island. Although we are unable to confirm Dr. Romay's citations in Bally's *Journals*, his reference to *Journal*, Num. 2, was of more than passing interest. The entry in the Library of Congress, *National Union Catalog Pre-1956 Imprints*, shows only one issue of the *Journal* which consisted of seventy-two pages and was published in 1803. The entry reads: "Founded by V. Bally and others. No more published?" Dr. Romay's reference to num. 2 suggests that more than one issue was printed. It might be added that Dr. Bally was absolutely convinced that yellow fever was contagious,[28] and this was one of the points that Dr. Romay disputed in his 1804 manuscript.

The two specific references in Bally's *Journal* to which Dr. Romay called attention were: the use of various agents by French and Arab doctors to treat yellow fever, and the advice given by Dr. Gilbert about spontaneous evacuations. We must refer the reader to the *Journals* themselves for confirmation of these points. The reference to Gilbert was undoubtedly to Dr. Nicolas-Pierre Gilbert (1751-1814). Judging from his bibliography, Dr. Gilbert was a colleague of Dr. Bally's on Santo Domingo. In 1803 Gilbert authored a volume on the *Medical History of the French Army at Saint-Domingue . . . or a Memoir on Yellow Fever and at the same time a Survey of the Medical Geography of that Colony* (Paris, Gabon and Co.). It was translated and published in German at Berlin in 1806. Thus it seems quite obvious that Bally and Gilbert were well acquainted, and that Bally cited Gilbert's observations on yellow fever in the *Journal.*[29]

Hopefully these brief discussions of some of the persons mentioned by Dr. Romay will eventually bring answers to the questions raised by our inability to confirm Dr. Romay's citations.

Now to the document itself and to the main points made by Dr. Romay about yellow fever as he had observed and read about it. First, he made several observations about its general characteristics and classification. Second, he noted the symptoms demonstrated by the victims of the disease. Third, the most effective cures for yellow fever included: tonics, stimulants, laxatives and bleedings. Fourth, he questioned the use of certain curatives as recommended by the French and Arab doctors: olive oil, lemon juice, various salves, and the application of hot glasses to the head. Fifth, Dr. Romay had definitely changed his mind about the contagiousness of yellow fever. Finally, he believed that it was the infernal and diabolical essence in the atmosphere of the Americas which, along with other things, caused the horrible epidemics of yellow fever in the New World.[30] Little did he realize that the "infernal and diabolical essence in the atmosphere" was a particular species of that pesky little mosquito which was probably buzzing about him as he wrote. It was nearly a century after Dr. Romay penned his essay, however, before another Cuban's extensive knowledge of yellow fever, Dr. Carlos Juan Finlay's, assisted in the positive identification of the infectious agent as the *Aedes aegypti.*[31]

Translation of Dr. Romay's manuscript • I would be unworthy of the profession I exercise and deserving of the execration of humanity, if I pretended to uphold my former opinions and, because of them, jeopardized human life. Candor and sincerity should glow in every line of a public author, and however it may mortify one's pride, it is necessary to admit one's original errors. This confession cannot discredit practitioners of an art larger than life, who depend principally upon observation and experience, which has changed its system many times as nature has condescended to reveal her precious secrets.

When I published a dissertation on *vomito negro* in 1797, I was aware that Makittrik [Makittrick], Pouppe-Desportes, Moultrie, Souvages [Sauvages],

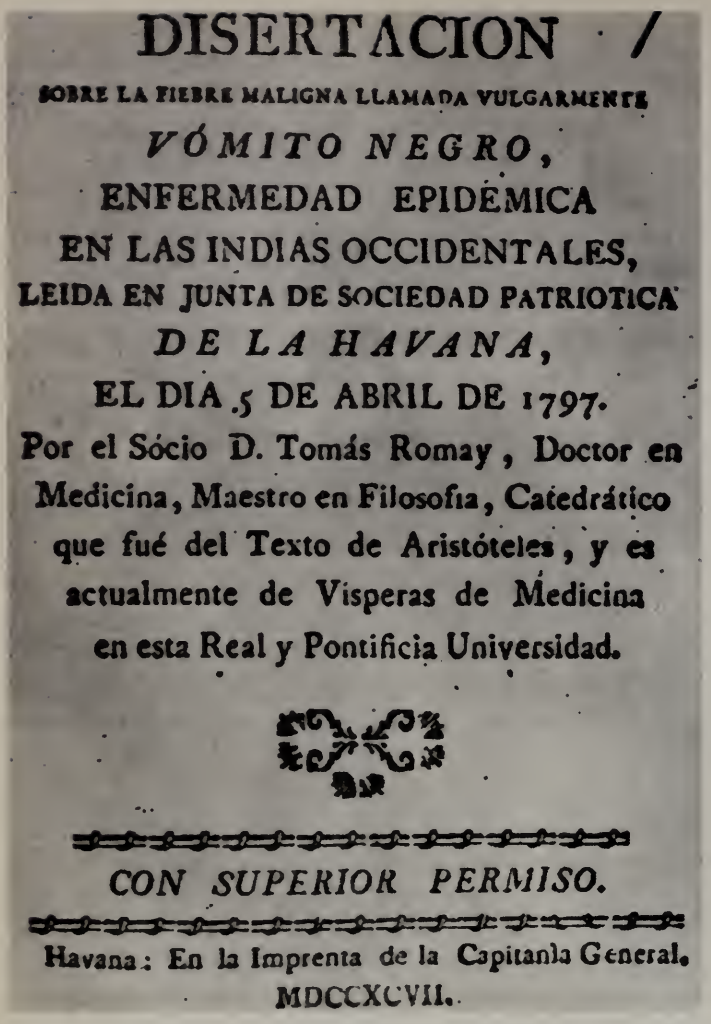

DISERTACION /
SOBRE LA FIEBRE MALIGNA LLAMADA VULGARMENTE
VÓMITO NEGRO,
ENFERMEDAD EPIDÉMICA
EN LAS INDIAS OCCIDENTALES,
LEIDA EN JUNTA DE SOCIEDAD PATRIOTICA
DE LA HAVANA,
EL DIA 5 DE ABRIL DE 1797.
Por el Sócio D. Tomás Romay, Doctor en Medicina, Maestro en Filosofia, Catedrático que fué del Texto de Aristóteles, y es actualmente de Visperas de Medicina en esta Real y Pontificia Universidad.
CON SUPERIOR PERMISO.
Havana: En la Imprenta de la Capitanía General.
MDCCXCVII.

Fig. 2—Title Page of Dr. Romay's 1797 Dissertation on Yellow Fever. Source: Jose Lopez Sanchez, *Tomas Romay Chacon: Obras Completas* (Havana: Academia de Ciencias de la Republica de Cuba, 1965), p. 62.

Cullen and other writers grouped this infirmity with typhus and considered it contagious. Nevertheless, my own observations at the time obliged me to dissent from their first opinion [grouping yellow fever with typhus], and seeing that they could not verify their second opinion with facts, I suspended judgment and spoke not a word about contagiousness in the third article of the dissertation, where I would have mentioned it among the causes that produce it.[32] But, while considering the fifth article of the dissertation the observations of Molan reached me, and since they seemed more convincing than the mere authority of other writers, I inopportunely inserted them there and adhered to his view.[33]

Since the publication of this dissertation I have not ceased to observe the latest epidemics, which have been almost annual, the character of yellow fever, its most effective cures, and whether or not it is contagious. At the same time, I have managed to read what foreigners and Spaniards have since written on the disease, prompted by the great epidemic which ravaged Andalucia in 1800.[34] Thus I have revised my opinion on the character and contagiousness of this malady.

The *flogistic* [inflammatory] symptoms of the first two or three days, and the putrefaction which follows, clearly show the characteristics of *synocha* and typhus and obliged me to group it among the *synochos* [continuous fevers]. Those who have observed its many different stages will forgive me an error, which even the illustrious Pinel could not avoid except by saying, "yellow fever of the Americas begins in the form of *doneningo-gastrica*,[35] moreover the symptoms which follow, and which Rouppe has described with such exactness, clearly identify the fever as of the fifth order — *ataxicas.*"[a,36]

If, however, the symptoms are ambiguous, then the illness must not be classified on that basis alone, but according to Brown, principally by the causes which produce them and in the remedies that cure them. If the inflammatory symptoms of yellow fever, even when they appear with great acuteness, disappear on the third day, in most cases with no preceding bowel movement; if the causes which produce this disease are so powerful as to induce weakness indirectly; and, if at the outset, tonics and later on various stimulants have proved more effective than bleedings and evacuation of bilious bad humors; then can one not agree with Bally that despite certain symptoms or irritation which occasionally predominate at the outset, the disease is ordinarily of the asthenic type?[37]

This year I have aided nine yellow fever patients; to each I prescribed tonics in the first days, and later stimulants the strength of which varied according to the patient's constitution and age, and according to the acuteness of the symptoms. Of these nine only one died, and doubtless his misfortune was caused by failure to apply the stimulants with greater power and effect. Among the patients was one whom I would have bled at another time; and in most I tried to dissipate the *erapula*[38] of the tongue with repeated doses of laxatives and with aids derived from the pathology of the body fluids.

Notwithstanding, some cases can occur in which these cures, as well as all anti-inflammatories are useful including bleeding. Gilbert supposes that this fever is the gravest of the bilious remittents, and having successfully tried spontaneous evacuations of this humor, advises following and even bringing about this natural movement.[b] Last year I followed, with fortunate results, a treatment opposite to that which I have followed this year. Frightened by the great and irreparable lethargy produced by bleedings in prior epidemics, I refrained from prescribed bleedings (however necessary they seemed) for the first two patients that had yellow fever, and used only benign evacuations and subsequently anti-inflammatories. Despite all this, the pulse remained strong until the fifth day, the eyes and face were very red, thirst was insatiable, the temperature high, and headache very

serious. Following delirium both patients died vomiting blood and emitting it abundantly through the nose, the anus, the pores of the tongue and gums.

In view of such a horrible catastrophe I returned to the practice of bleeding. I have performed twenty bleedings, repeating it up to three times in some patients, and only one has died — and that due to lack of effective assistance. Such contradictory results and anomalies so diametrically opposed perplexed me greatly. I could attribute the cause of this difference only to the atmosphere, and, not surprisingly, I suspected along with Frabuc that the air in America lacks the divine essence that Hippocrates attributed to air, and has instead an infernal and diabolical essence. I noticed no difference in temperature between this year and last; there has been more rain this year, but not enough to make such a difference.

The powerful effects attributed to rubbing with olive oil in the attached paper are also an incomprehensible mystery to me.[39] The French navy doctors of Santo Domingo, believing that this sickness is produced by a malignant miasma which instantly affects the entire skin, have persistently sought an agent able to neutralize it and diminish its harmful character. Bally, who calls this fever *miasmatica-ataxica*[40] in keeping with the empiricism of his country, recommends rubbing with lemon juice at the outset without omitting the use of stimulants. They apply the lemon juice over the entire body, and smear *muriate de mercurio dulce*[41] onto the blistered sores which cover the nape of the neck and the upper abdomen. M. Francois, without omitting the application of lemon juice in the first two days, later bathed patients with a mixture of quinine and vinegar, rubbed the spine with *Fioravanti*[42] balm, powerful alkali, camphor dissolved in ether, and cantharide extract.[43] Finally, imitating the practice of Arab doctors, he applied five or six hot glasses to the cranium.[c]

In eight years I have seen only one case which suggests the contagiousness of yellow fever. The constant heat, the humid and mephitic [noxious] breezes, hard work, violent passions and abuse of spirituous liquors are the causes of this disease among non-acclimated Europeans. More susceptible to the disease are those who come from a cold country, or those who have lately resided in one. All the observations made in recent years in the United States prove that these causes alone produced the epidemics which ravaged its provinces. Such has been the case of Philadelphia in 1793, Baltimore in 1794, and New York and Norfolk in 1796-97. Deveze proved with most convincing evidence that the Philadelphia epidemic was not propagated by contagion. Dr. Moseley, who has examined the matter with the most distinguished doctors of the Anglo-American colonies for four years, examined all the evidence pro and con, is inclined to believe that yellow fever is not contagious.

Fitler claims, contrary to Dr. Currie of Philadelphia, that the disease was not introduced by the brigantine *Zephyr*. In support of his opinion he cites the authority of Dr. Smith in his letter to Buel, in which he explains that neither Dr. Creat nor anyone else contracted yellow fever on board said ship. The celebrated Rhus [Rush?] expressly denies that the disease is contagious, as did Lind much earlier in his treatise on the diseases of sailors. Dr. Bruce of Barbasa makes no mention of contagion in his memoir on yellow fever; nor does Mr. Dazile in his work on tropical diseases which goes to great lengths to explain the causes of death among Europeans in these climates.

Finally, Gilbert poses the question of whether or not the fever which exterminated the army of General Leclerc was contagious. He answers in the negative, as do many of his colleagues. This illness, he says, is not communicated from an ailing, living body to those in contact with it unless they are exposed to the same causes; for then they would easily be infected by the putrid and gangrenous miasmas to which the predisposition of their humors is very similar.

Havana, June 27, 1804
Dr. Tomas Romay

Dr. Romay's Notes to his Manuscript

a. Nosographie Philosophique, tom. prem. f XXIV.

b. Journal des officiers de Sante de Saint Domingue, num. 1.

c. Ibid., *num. 2.*

Notes to the Introduction

1. Jose Lopez Sanchez, *Tomas Romay Chacon: Obras Completas*. 2 vols. (Havana: *Academia de Ciencias de la Republica de Cuba*, 1965). These volumes were published to celebrate the 200th anniversary of Dr. Romay's birth. An earlier edition of the *Obras Completas* with a prologue by Ramon F. Valdes appeared in 1858.
2. The document is identified as MS 18698[10] in the *Biblioteca Nacional*.
3. For more biographical data see Lopez, *Obras Completas*, I, Introduction; Jose Lopez Sanchez, *Vida y Obra del Sabio Medico Habanero: Dr. Tomas Romay Chacon* (Havana: *Editorial Libreria Selecta*, 1950), 23-52; and *Enciclopedia Universal Ilustrada: Europeo-Americana*, LII, 189. The latter should be used with caution because of some obvious errors in the entry for Dr. Romay.
4. Lopez, *Obras Completas*, I, p. 3 of introduction.
5. Ibid.; Lopez, *Vida*, 145-78.
6. Lopez, *Obras Completas*, II, 267-82. Those pages contain his "Chronological Bibliography" with the articles arranged by years, including a summary of each article, its significance and the publication data.
7. Lopez, *Obras Completas*, I, 3-7.
8. Gilberto R. Cepero, M.D., "Notes on the Evolution of Medicine in Colonial Cuba," *Journal of the Florida Medical Association*, 64, No. 8 (August, 1977), 570. See also Lopez, *Vida*, 115, 127-29ff.
9. Lopez, *Vida*, 127-29. See Ibid., 113-43, on Romay's role in the introduction and development of the smallpox vaccination program in Cuba.
10. Ibid., 113.

11. J. C. Gros, M.D., "The 'General Calixto Gracia' Hospital: Its History," *Journal of the Florida Medical Association*, 64, No. 8 (August, 1977), 586.
12. Lopez, *Obras Completas*, I, pp. 5-6 of introduction; Lopez, *Vida*, 229-39.
13. Lopez, *Vida*, 159-211.
14. Among others see the three articles on yellow fever in the *Journal of the Florida Medical Association*, 58, No. 8 (August, 1971), 31-52; See also Henry Rose Carter, *Yellow Fever: An Epidemiological and Historical Study of its Place of Origin* (Baltimore: Williams and Wilkins, 1931); George Augustin, *History of Yellow Fever* (New Orleans: Searcy and Pfaff, Ltd., 1909).
15. Lopez, *Vidas*, 91-93.
16. Ibid., 93-104; Lopez, *Obras Completas*, I, 65-84.
17. Lopez, *Obras Completas*, I, p. 3 of introduction; Lopez, *Vida*, 97-99; *Enciclopedia Universal Ilustrada: Europeo-Americana*, LII, 189.
18. Lopez, *Obras Completas*, I, 84-86.
19. Ibid., 87-90. The paper was published on September 21 and 25, 1800, in the *Papel Periodico de la Havana*, Nos. 72 and 73. Many of Romay's works were published in that paper.
20. Augustin, *History of Yellow Fever*, 67, 484, 492-93.
21. According to Lopez, *Vida*, 104, French authors (M.D.'s) provided the best studies of yellow fever in the pre-Finlay era.
22. Lopez, *Obras Completas*, I, 90-92.
23. Joseph I. Waring, M.D., "John Moultrie Jr., M.D., Lieutenant Governor of East Florida: His Thesis on Yellow Fever," *Journal of the Florida Medical Association*, 54, No. 8 (August, 1967), 772-77.
24. *Encyclopedia Britannica* (New York: Charles Scribner's Sons, 1885), XIX, 106; Library of Congress, *National Union Catalog Pre-1956 Imprints*, see listing under Pinel for his publications and publishing data.
25. *Nosographie philosophique* . . . 3 vols. (Paris: The Press of Feugueray, 1802-03), I, 255, 261.
26. Library of Congress, *National Union Catalog Pre-1956 Imprints*, see entry for Rouppe.
27. *Dictionnaire de Biographie Francaise* (Paris: *Librarie LeTouzey et Ane*, 1948), IV, 1507-08.
28. Augustin, *History of Yellow Fever*, 104.
29. No biographical sketch of Dr. Gilbert could be located and the information herein is from the Library of Congress, *National Union Catalog Pre-1956 Imprints*.
30. In his 1797 dissertation, Dr. Romay blamed the hot and humid climate in America for producing the two qualities, inflammation and putrefaction, that caused yellow fever, Lopez, *Obras Completas*, I, 70-72.
31. John E. Porter, Ph.D. and Harry D. Pratt, Ph.D., "Aedes Aegypti Control and Eradication Programs in the United States," *Journal of the Florida Medical Association*, 58, No. 8 (August, 1971), 51. Of course, Dr. Finlay had identified the carrier as early as 1881, but it was not until 1900 that the United States Army Yellow Fever Commission in Havana proved without a doubt that the *Aedes Aegypti* was the agent.

Translators Notes to Manuscript

All the information within the brackets in the mss. were added by the translators. Definitions of the various terms in the following notes came from a variety of dictionaries.

32. Lopez, *Obras Completas*, I, 70-72.
33. Ibid., I, 74-76. See especially p. 75 on Jaime Molan.
34. Augustin, *History of Yellow Fever*, 484.
35. Bowel movements.
36. Failure of muscle coordination, or lack of muscle tone.
37. Weak; debilitating.
38. We could not find a dictionary which defined this word. In conversations with Mrs. Betty Vickers and Dr. Hector Del Castillo it seems apparent that Dr. Romay was referring to either the furry coating and/or the swelling and redness which appear on the tongues of yellow fever victims.
38. See also Lopez, *Obras Completas*, I, 90-92.
40. Characterized by weakness and loss of tone in the muscles of the stomach.
41. Hydrochloric acid with a base.
42. We could not discover a definition for *Fioravanti*.
43. A preparation of dried beetles, esp. the blister beetles, used externally as a rubefacient and vesicatory, and internally as a diuretic and stimulant.

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Spanish medical care in the Mobile district: advanced or retarded

Sir Jack D.L. Holmes, Ph.D.

When the great British Prime Minister Benjamin Disraeli wrote, "The health of the people is really the foundation upon which all their happiness and all their powers as a State depend,"[1] he might have revealed the philosophy of those Spanish Bourbon monarchs, Charles III (1759-1788) and Charles IV (1788-1808). In fact, the crown's interest in the health and longevity of Spanish vassals at home and in the colonies dates at least to the time of Philip II and his 1570 law which stated, "Since we desire that our vassals enjoy a long and healthy life, it is our duty to provide them with physicians and professors of medicine." For that reason, Spain established in the universities of the New World, which preceded Harvard by more than a century, faculties of medicine to train medical doctors to serve the people.[2] In laws passed in 1621 and 1648 it was forbidden to practice medicine or surgery without a license and a degree.[3] In 1579 it was declared that no one could be granted a license without being examined, whether he be "physician, surgeon, apothecary, barber, or bone-setter."[4] Governors and viceroys were required, by a law passed in 1538, to inspect the medicines in the pharmacies to determine their quality and freshness and to throw away those which had deteriorated because their use "could cause harm."[5]

Although Louisiana and West Florida did not fit the traditional Spanish-American model, certain government aims were carried out with the effective occupation of New Orleans in 1769 and that of Mobile in 1780. The role of the "witch doctor" among Indian populations which so plagued governors in Mexico and the rest of Latin America[6] played no role whatever in the vast, thinly populated interior of North America. Yet, from the very beginning, Spanish *nobleza obligatoria*, that fine sense of paternal responsibility of the government for its subjects, prevailed. In the midst of writing an entirely new body of laws, reorganizing local and provincial government, setting religious parishes and naming priests, promoting the army and militia and regulating billiard parlors, Governor Alexander O'Reilly had time to devote to medical needs.[7] His regulation of February 12, 1770, set forth the Spanish philosophy on medical care and the regulations which should govern its practice in Louisiana.

"The first care of a wise government being to delimit the rights of each individual and to watch over the welfare of its citizens, I have deemed it my duty to establish, as in all civilized states, the following regulations concerning the practice of medicine and surgery.

"Medicine is the practice of studying derangements of health, the means of preserving and restoring the latter, and of curing the former. This study embraces three parts, namely: medicine proper, which is the science of recognizing diseases and the relation which they have with remedies, and of prescribing the latter together with the diet. The other

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two parts, which are surgery and pharmacy, are its attendants and have their special field. Surgery includes the use in general of the hands and of external remedies. Pharmacy is concerned, generally speaking, with the preparation of remedies.''[8]

Speaking of this progressive regulation, New Orleans medical historian Rudolph Matas was most unkind and revealed the same type of prejudice against Spanish institutions which generally characterize non-Spanish writings. In an otherwise scholarly treatment of early medical accomplishments in Europe, Joseph F. Payne discusses Austria, the British Isles, France and Italy, but makes absolutely no mention of Spanish achievements, almost as if none existed.[9] Matas is typical of the ''black legend'' writers whose anti-Spanish bias is based more on prejudice than on scientific, objective research: ''Spanish medicine, like other intellectual and cultural activities, under the dead hand of rigid ecclesiastical censorship had lagged behind developments in the rest of Western Europe . . . Class distinctions reinforced and helped support the belief that the scholastic sophistry of the university trained physicians was far superior to the more pragmatic knowledge of the surgeons . . . O'Reilly was especially concerned with insuring the subordination of surgeons to physicians.''[10]

On the other hand, there is little argument that Spanish care in the regulation of pharmacy was advanced beyond its time: ''Pharmacy was recognized legally as a distinct branch of the medical arts for the first time in America in an edict issued by . . . O'Reilly . . . Although intended to regulate surgery, the edict is a milestone in the history of pharmacy in America since it proclaimed that:

'Medicine . . . embraces three parts . . . Pharmacy is concerned, generally speaking, with the preparation of remedies'.''[11]

Jean Peyroux de Rochemolive petitioned the New Orleans Cabildo (municipal council) on March 12, 1769, asking permission to practice pharmacy in New Orleans and at the January 12, 1770, meeting he presented the results of tests before local physicians and surgeons and copies of his degrees attesting to his skill.[12] He was granted permission and in 1791, when a city census was taken, he is listed as an apothecary living on Dumaine Street.[13] The pharmacy rules seem reasonable by modern standards:

1st, The pharmacist shall keep a register in proper form to write down the name and require signatures of those obtaining prescriptions. To avoid abuses, no one will be listed in the book who is not a resident and known in the neighborhood.

2nd, The pharmacist will sell no prescriptions, except at an honest price and will post a schedule of his fees where his customers may see it.

3rd, He will see to it that no strangers coming to town receive any prescriptions without advising the police, but will insure that local residents are provided with their drugs.

4th, He will pay particular attention in filling the prescriptions to follow the physicians' instructions exactly without alteration on his own.

5th, Until the Spanish system of measurements is known, the pharmacist shall conform to the Paris laws.

6th, He will follow no magistrate's order which is not that of his own district's head.

7th, He shall make frequent inspection of his medicines and throw away those which are spoiled or out-dated.[14]

At a time when England was still utilizing the inoculation of smallpox agents to check the disease, this partially useful but potentially dangerous system was also used in Spain and other European nations. Edward Jenner (1749-1823), who suggested the idea of vaccination in 1796, had a tremendous influence on the scientific study of infectious diseases. Indeed, England seemed to surpass everyone in medical advances during the late 18th century.[15]

Education and training ● Yet Spain was not as backward as English sources would seem to indicate. An interesting survey of Spanish medical progress in the 1790's is given in the *memorias* of Spanish Minister of State, Manuel de Godoy, Prince of Peace. Noting the dearth of sound veterinary training, Godoy urged the creation of a basic school of veterinary science to train people to care for animals. Specialists were given grants of money to travel to other lands and observe their ideas. On October 18, 1795, the Spanish Veterinary School opened under the guidance of Segismundo Malats, a graduate of the ''better schools of France,'' and Hipolito Estevez. The school began with 30 students who following graduation spread the ideas thus learned to all corners of Spain and with the publication of books concerning the care and treatment of horses and cattle, Spain's scientific attention to medical care for animals flourished.[16]

Godoy noticed that the army lacked properly trained surgeons and he began to ask why. The answers were astonishing. No one had given any attention to medical training, and the ignorance of Spanish surgeons and physicians was abysmal. No wonder the foreign writers looked down on Spain. Godoy took upon himself the reorganization of the medical training program in Spain by first revising the regulations and by establishing medical colleges at Madrid, Barcelona and Cadiz, and by extension classes taught at Burgos and Santiago de Compostela. His work resulted in the establishment of the San Carlos Clinic in Madrid where medical students could obtain practical experience treating the sick. Twelve full scholarships were given to promising

students in 1793 and when the new medical school was opened in Madrid the same year royal support for medical education was already assured.[17]

At the same time, applied sciences such as botany and chemistry were utilized in medical research and on May 6, 1804, new regulations set forth a program of medical-surgical studies complete with government grants. Because foreigners had made such important discoveries in medicine, their works were translated into Spanish on a large scale: general works, specialized studies of ulcers, forensic medicine, ophthalmology, biochemistry. No area of medical knowledge was left in the dark. Spain wanted to know.[18]

Spain was humble enough to recognize the value in foreign medical treatises but Spain also produced medical works of its own, some of which were to be received abroad with praise. Godoy lists such studies of lung and chest infections by Antonio Corbella and a study of the use of quinine by Hipolito Ruiz in 1796. The Royal Laboratory of Segovia issued yearly reports which were masterpieces of medical knowledge written by Luis Proust. Jose Iberti, one of the world's foremost medical experts (not mentioned in English works) and corresponding member of medical societies in Bologna, Paris and London, was a leading professor of the new Madrid medical school.[19]

Two works are of special consideration, inasmuch as they were of particular importance to Louisiana. Dr. Francisco Gil was a surgeon at the Monastery of San Lorenzo in Spain, a distinguished member of the Madrid Academy of Medicine. His work on how to cure and prevent smallpox *(viruelas)* was not only sent to Louisiana for filing in the Cabildo archives, but in its early section it refers to the quarantine steps taken by Governor Bernardo de Galvez in 1779 in the face of stubborn opposition from the Cabildo members and even the medical community.[20] Galvez felt the only way to check the disease was to isolate the cases at a quarantine infirmary across the river from New Orleans, well tended by nurses who had already suffered smallpox and by a resident physician. So effective was his treatment that the only death was that of a man who refused to leave the city. Unfortunately Rudolph Matas misinterprets completely the objections raised by the Cabildo judging from the unflattering references to them in the book, preferring to state it was a matter of dispute between physicians and surgeons.[21]

Another work which had far-reaching impact on Louisiana and West Florida was Jose Sanchez, *Relacion de la epidemia de calenturas putridas, padecida en el navio de S.M. nombrado el Mino . . . su curacion por el metodo del doctor Don Joseph Masdevall,* published in Madrid in 1789. It went through several editions and was translated into Italian.[22] Dr. Masdevall's work was also printed in New Orleans by *emigre* printer Louis Duclot in 1796 where it earned the reputation as the first medical work published in Louisiana.[23] It could not have come at a better time. New Orleans in 1796 was all but ravaged by yellow fever and Dr. Masdevall's regimen was very popular.[24]

Hospitals ● From the beginning of Spanish rule in Louisiana, the government established hospitals at outlying posts as well as within the town of New Orleans itself. The story of this medical attention has been told before,[25] but what about the Mobile District, that amorphous section of British West Florida captured by Bernardo de Galvez in March, 1780 and created into a separate government under the name of Florida Occidental . . . West Florida?[26] The medical history of the Mobile District is, unfortunately, still confined to the dusty archives of Spain and Mexico and, apparently because of the language barrier, medical historians have chosen to leave it alone. This is sad, for during the 33 year dominion of Spain in the Mobile District, there are literally hundreds of extant documents detailing care and treatment of the ill.

Because of the nature of medical care in the Mobile District, we are fortunate in having documental evidence in quantity. There was no medical board or physicians' group to govern the hospital. On the contrary, the hospital was an integral part of the duties performed by the government revenue agent, known as *guarda-almacen.* He would be an agent of the Internal Revenue Service in the United States today, but in the 18th century he was a loyal and dedicated member of Spain's awesome Secretary of the Treasury. The Revenue Inspector General for all of Louisiana and West Florida was an officer in New Orleans known as the Intendant. He was quasi-independent of the military and political Governor General, inasmuch as he communicated directly with the Minister of Grace and Justice in Madrid. During the majority of years the Intendant for the Mobile District was Juan Buenaventura Morales.[27]

The Intendant's agent at Mobile was called *"guarda-almacen,"* something midway between a revenue agent and a quartermaster general. His activities embraced four areas, *viz.*, fortification, Indian supplies, artillery and . . . *THE HOSPITAL!*[28] It was a bookkeeping nightmare for anyone, and in Mobile the problems were enormous but, fortunately, there was a brilliant revenue agent exercising the job who managed to overcome all tribulations. His name was Miguel Eslava and his descendants live on in the deep south today.

Eslava was born in Mexico City, the son of Thomas de Eslava and Dona Maria Giron, sometime between 1751 and 1755. He died in Mobile on September 17, 1823.[29] He took over as *guarda-almacen* with special jurisdiction over the royal hospital on December 1, 1784.[30] He was not the first man in Mobile, however to run the hospital.

Governor Bernardo de Galvez had no sooner conquered Mobile from the British in March, 1780, than he named Lorenzo Chouriac as *guarda-almacen*, the same job he had in upper Louisana. His salary was set at $30 per month plus a daily ration. He served until replaced by Eslava in 1784.[31]

Under the direction of Eslava who was responsible for salaries, provisions, rations, equipment and all hospital needs was a surgeon. In larger cities, the office of comptroller, commissioner for entry, and clothes-keeper were held by different individuals but, in Mobile, Eslava did it all. He did have the surgeon-in-chief, however, and that was Dr. Pedro de la Puente. Eslava and Puente both drew the same yearly salary . . . $600.[32] It was obvious that neither would become wealthy on salary alone.

Dr. Puente came with Galvez in the expedition which conquered Mobile in 1780. He had served aboard the ill-fated frigate *El Volante* which, unfortunately for Puente, ran aground and had to be abandoned before the start of the siege. After the British surrendered, however, Dr. Puente was named surgeon of the royal hospital at a salary of $40 per month to date from his commission, April 15,1780.[33]

When the government budget was drawn up for Mobile in 1785, Dr. Puente was given a raise to $600 per year.[34] He apparently served through March 31, 1786, at which time he was transferred to the Third Battalion of the Louisiana Infantry Regiment stationed at Pensacola.[35] From his 1796 petition we are able to determine he studied surgery at the Royal College of Surgery of San Fernando, located at the naval base of Cadiz. He had asked that the final six months of study necessary to complete his bachelor's degree might be waived and that he receive his degree and permission to practice medicine.[36] By 1801 he was still serving in that regiment stationed at the royal hospital of Fort San Marcos de Apalache, present day St. Mark's, Florida.[37]

Dr. Puente's petition for a six-months waiver recalls that in 1795 Carlos IV had decreed that all surgeons be required to have a bachelor's degree in their art and be examined by an appropriate board of medical people.[38]

In addition to the Mobile hospital, from which patients might be sent to Pensacola or New Orleans or even Havana for convalescence, there were smaller hospitals along the Tombigbee River where Spain maintained military posts. Fort San Esteban de Tombecbe, located near the site of present-day St. Stephens, Alabama, had a hospital of sorts maintained by the *guarda-almacen*, Francisco Fontanilla. His careful accounts show exactly how much was provided for the patients of the small hospital over a precise period of time.[39]

Although he was not a Spaniard, in fact, he probably had come to the Mobile District as early as the French dominion, Dr. John Chastang was a skilled surgeon whose medical skill was utilized by the Spanish government. A most remarkable gentleman during colonial times, Dr. Chastang had at first lived at Mobile where on June 20, 1780, he gave liberty to his Negress slave Louison (or Luisa) and her children.[40] It is good that he did so; the children were his. Dr. Chastang recognized in the church records one of his natural sons, Basilio. He was the "Big Daddy" of Harigay Hall, the family plantation, where dozens of mixed blood black and white children grew to maturity and a recognized position in society as some of Mobile's earliest cattlemen. Louison or Luisa is a study in herself. Not only was she the consort of Dr. Chastang and the mother of his plentiful brood, but she bid successfully on the contract to supply baked bread to the post of Fort San Esteban de Tombecbe.[41] Dr. Chastang had been on the Spanish payroll for some time as resident surgeon for the Mobile and San Esteban posts, earning a munificent sum of $20-25 monthly.[42]

In addition to the surgeon and physician which Mobile's hospital had from time to time, there were what we would call "medics" or as the Spaniards labeled them, "*practicantes*," practitioners. They had a rudimentary skill in medicine but obviously not sufficient to take over from the surgeons and physicians. Rafael Hidalgo, who married Elizabeth Chastang on April 10, 1795, was head medic,[43] while Juan Gallegos rose from medic to surgeon.[44]

When patients suffering from dysentery, fever, gout, ulcers or a host of other maladies appeared at the Mobile hospital, they turned on Dauphin Street between St. Joseph and Conception streets. It was just a stone's throw from the mercantile house of John Forbes & Co., which Scottish firm often imported the necessary medicines in use.[45] These medicines ranged from the benign to the sublime. On December 31, 1797, for example, Francisco Fontanilla signed for six ounces of "moscas Cantaridas" . . . Spanish fly! Perhaps it is ironic that lightning struck his small hospital on March 15 following, causing a complete inundation of the medicines![46]

Care and treatment • Surgeons and physicians were required to make regular calls on their patients, at 5 A.M. and 3 P.M. in the summer and 6 A.M. and 2 P.M. in the winter. They were also required to check on the freshness and efficacy of medicines. It was a hierarchy of medical responsibility from the admission clerk to the comptroller, nurses, orderlies, clothes supervisors, etc. The diet was varied, and according to records kept at Mobile and San Esteban, a substantial amount of fresh beef and pork and poultry was provided to the patients.

Spanish regulations stated that "each bed should consist of a leather cot, or of boards with the corresponding width if it is of the former a matting

covering shall be put on it and if of the latter a wool mattress or a sack filled with straw, grass or other similar material according to what the country supplies." The linens consisted of two sheets "of fine Brabant linen or burlap," a pillow of the same material. "These shall be changed whenever they are soiled although if by reason of the warm climate the physicians estimate the mattresses to be harmful in the rigorous months of the spring they must be removed."[47]

A type of chamber pot or "bedpan" was covered with wool or some similar material, as an open pot would be dangerous. An early type of "mentholator" using lavender fumes sat beside a chocolate pot and a small lantern. For cold nights a coal brazier was provided but with instructions not to burn it inside where the carbon monoxide might kill the patients. Tin candlesticks for the candles providing light were considered indispensable. A shaving kit "to shave the head, genitals and other parts in which there is hair" was stored beside several boxes for splints. Patients were required to undress and put on nightshirts "which reach below the knees with long sleeves without cuffs" so as to get rid of vermin they might bring into the hospital with their street clothes.

Rations were of an interesting variety. An ordinary ration consisted of a pound of fresh beef with bone, one ounce of bacon, another of chickpeas, 14 ounces of bread, and one-half ounce of lard. Breakfast soup included half the beef and a corresponding quantity of the other ingredients.

In addition to beef, there were rations of hen egg, soup, chicken, squab, vermicelli, rice, roast beef and chicken, meatballs, and hash. A diet ration cut the quantity but not the ingredients. Wine ration, under the Brunonian conception of feed-a-cold, feed *everything*, was 12 ounces, half of which was to be drunk at dinner (midday meal) and the other half at supper (night meal). A chocolate ration, special diet for those who had taken a laxative, ulcer diet, milk ration, and wheat and rice flour gruel rations completed the regimen, along with cinnamon, salt and saffron.[48]

The government sponsored medical care was intended to help the poor, soldiers, forced labor prisoners, and helpless members of the society. On one occasion in the nearby Natchez District, when the Intendant criticized the governor for allowing transients to be cared for in the royal hospital at the king's expense, Governor Manuel Gayoso de Lemos replied, charity and the demands of humanity made him do it.[49]

Among the most common medicines in use in the Mobile hospitals were Glauber's Salts, quinine, cream of tarter and mercury, the last-named being used to cure venereal disease in a rather painful procedure.[50]

There were more similarities than differences between Spanish care in the Mobile District and neighboring British techniques or those of the Americans after 1799. The following treatment by British doctors treating a Spaniard from the Aragon Regiment wounded in the battle for Pensacola in 1781 is typical of the treatments employed:

"First, That the patient be mov'd into a front Room which should be kept clean & cool as possible.

Second, that the wound wip'd clean & dressed with finest dry lint, over which a warm poultice made of oatmeal softened with olive oil should be applied & these dressings renewed twice a Day.

Third, The patient should be put into a warm Bath and to remain there for ten minutes, if his strength will admit. This to be repeated once in Twenty-four hours if possible, till the spasm is remov'd.

Fourth, The opium to be continued with an equal quantity of Mosel (wine) added.

Fifth, A Strong Decoction of the Peruvian Bark to be given in the quantity of half a pint every hour, or as often as his stomach will bear.

Sixth, The patient should be nourish'd with light Broths, his strength supported with a glass of generous wine three or four times a Day, & his body kept open with Emollient clysters.

Seventh, The Patient should be frequently shifted with clean linen, which should first be well air'd."[51]

When Americans under Captain Bartholomew Schaumburgh began the construction of Fort Stoddard in 1799, hospital supplies . . . rather, the *lack* of hospital supplies . . . was a constant complaint. One of the surgeons, Dr. Hogland, "arriv'd here without any *thing*," complained Captain Schaumburgh, "no, not even a Chirurgical Instrument. If one of my men should be so unfortunate as to break an arm or leg & should it be necessary to amputate the limb, I should have to chop it off with a broad ax!"[52]

When a shipment of medicines to Fort Confederation arrived in poor condition in 1796, they were replaced with fresh drugs from New Orleans.[53] Since all these medicines had to be signed for, it is possible to know exactly how much was sent to whom and for what purpose, thus making medical history research into the Spanish Mobile District possible. For 15 years these records, microfilm copies of the originals from Spain, have gathered dust in the major university libraries of Alabama. Auburn, Tuscaloosa and Birmingham all have a set of the so-called Holmes Collection concerning Alabama, 1780-1813. It is up to Spanish fluent researchers to make use of the vast riches which are at their fingertips.

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References

1. From a speech delivered on July 24, 1877, and quoted in Jack D.L. Holmes, A History of the University of Alabama Hospitals (Birmingham: Hospital Auxiliary, 1974), 7.
2. *Recopilacion de leyes de los reinos de las Indias* (4 vols.; Madrid: Boix, 1841), Libro V., Titulo VI., ley 1.
3. *Ibid.*, ley 4.
4. *Ibid.*, ley 6.
5. *Ibid.*, ley 7.
6. John Tate Lanning, "The Illicit Practice of Medicine in the Spanish Empire in America," in *Homenaje a Don Jose Maria de la Pena y Camara*, edited by Ernest J. Burrus, S.J., and George P. Hammond (Madrid: Ediciones Jose Porrua Turanzas, 1969), 141-179.
7. Jack D.L. Holmes, "Some Irish Officers in Spanish Louisiana," The Irish Sword (Dublin), VI, No. 25 (Winter, 1964), 234-240.
8. Douglas C. McMurtrie (trans. and ed.), "A Louisiana Decree of 1770 Relative to the Practice of Medicine and Surgery," New Orleans Medical and Surgical Journal, LXXXVI (July, 1933), 7-11.
9. Joseph Frank Payne, "Medicine," Encyclopaedia Britannica, 11th edition (1910), XVIII, 41-64.
10. Rudolph Matas, The Rudolph Matas History of Medicine in Louisiana, edited by John Duffy (2 vols.; Baton Rouge: LSU Press, 1958, 1962), I, 174.
11. David L. Cowen, "Louisiana, Pioneer in the Regulation of Pharmacy," Louisiana Historical Quarterly, XVI, No. 2 (April, 1943), 330-331.
12. Minutes of the New Orleans Cabildo, March 12, 1769 and January 12, 1770, New Orleans Public Library Archives.
13. New Orleans Census for November 6, 1791, in *ibid.*
14. Order approving Peyroux de Rochemolive to practice by Governor Luis de Unzaga y Amezaga, New Orleans, January 12, 1770, in the Minutes of the New Orleans Cabildo.
15. Payne, "Medicine," 53.
16. Manuel de Godoy, *Memorias de Don Manuel Godoy, Principe de la Paz, o sea cuenta dada de su vida politica; para servir a la historia del reinado del Senor Don Carlos IV de Borbon* (6 vols.; Gerona: Libreria de Vicente Oliva, 1839-1841), II, 130-32; Josef Martres y Chavarry, *Instruccion sobre el regimen y gobierno de la cria de caballos en Espana, segun la ordenanza de 8 de septiembre de 1789* (Madrid: Imprenta Real, 1826), iii-iv.
17. Godoy, Memorias, II, 132-135.
18. *Ibid.*, 134-135.
19. *Ibid.*, 134-137.
20. Dr. Francisco Gil, *Disertacion fisico-medica, en la qual se prescribe un metodo seguro para preservar a los pueblos de viruelas hasta lograr la completa extincion de ellas en todo el reyno* (Madrid: D. Joachin Ibarra, 1784). My copy is based on the original example sent to Mexico's viceroy by Joseph de Galvez, Aranjuez, April 15, 1785, in Archivo General de la Nacion (Mexico), Reales Cedulas, CXXX, fols. 265-352. According to John B. Blake (comp.), A Short Title Catalogue of Eighteenth Century Printed Books in the National Library of Medicine (Washington: Government Printing Office, 1979), 175, a second edition was published in Madrid in 1786 and one in Mexico in 1796. It was published at Naples in 1789 under the title, Dissertazione fisico-medica in cui si prescrive un metodo sicuro da preservare i popoli dal vajuolo.
21. Gil, *Disertacion*, v-vii, tells the story of the 1779 quarantine of smallpox of New Orleans.
22. Blake, *Catalogue of Eighteenth-Century Books*, 291.
23. Matas, History of Medicine, T, 160-162.
24. Jack D.L. Holmes, "The New Orleans Yellow Fever Epidemic of 1796 as Seen by the Baron de Pontalba," The Alabama Journal of Medical Sciences, II, No. 2 (April, 1965), 205-215; Jo Ann Carrigan, "The Pestilence of 1796—New Orleans' First Officially-Recorded Yellow Fever Epidemic," McNeese Review, XIII (1962), 27-36.
25. Jack D.L. Holmes, "Medical Practice in the Lower Mississippi Valley during the Spanish Period, 1769-1803," The Alabama Journal of Medical Sciences, I, No. 3 (July, 1964), 332-338; and "Medical Practice in New Orleans: Colonial Period," in *ibid.*, VI, No. 4 (October, 1969), 433-411.
26. Jack D.L. Holmes, "Bernardo de Galvez: Spain's 'Man of the Hour' During the American Revolution," *Cardinales de Dos Independencias (Noreste de Mexico—Sureste de los Estados Unidos)*, edited by Beatriz Ruiz Gaytan and Samuel Proctor, et al. (Mexico: Editorial Jus for Cultural Banamex, 1978), 161-174.
27. On the enigmatic career of Morales, see Jack D.L. Holmes, "*Dramatis Personae* in Spanish Louisiana," *Louisiana Studies*, VI, No. 2 (Summer, 1967), 155-161.
28. An example of instructions by which the *guarda-almacen* operated is in the "instruccion" to Pablo de Paulis Palmero at the post of San Marcos de Apalache, without date or place, in Archivo General de Indias, Papeles procedentes de la isla de Cuba (hereafter cited as AGI, PC), legajo 2359.
29. Service records for Eslava, 1789, 1793 and 1794, in AGI, PC legajos 202, 565; obituary, Mobile Commercial Register, September 18, 1823, p. 3, col. 4.
30. Hoja de servcios, Dec. 31, 1793, AGI, PC, leg. 565.
31. Draft appointment, New Orleans, AGI, PC, leg. 113; pay records of Eslava, in AGI, PC, leg. 538-A.
32. Jose de Galvez (Minister of the Indies) to Intendant of Louisiana (Martin Navarro), Madrid, December 7, 1785, AGI, PC, leg. 652.
33. Appointment, April 15, 1780, AGI, PC, leg. 113.
34. Havana Regulation of March 20, 1785, AGI, PC, leg. 652.
35. Francisco Bouligny to Baron de Carondelet, New Orleans, February 22, 1796, AGI, PC leg. 33.
36. *Ibid.*
37. Dr. Puente's report on illness of Ursino Durel, Fort San Marcos de Apalache, August 8, 1801, AGI, PC, leg. 72.
38. Royal Decree, June 20, 1795, regarding surgeons, Aranjuez, AGI, PC, leg. 59.
39. He was Spanish; his wife, Maria Andaza, a German. He took over the guarda-almacen duties from Sargeant Juan Hernando on November 1, 1784, and served until its evacuation in 1799. On this post and its brief ten-year history, see Jack D.L. Holmes, "Notes on the Spanish Fort San Esteban de Tombecbe," The Alabama Review, XVIII, No. 4 (October, 1965), 281-290; Fontanilla's records, AGI, PC, leg. 538-A.
40. Manumission, Mobile, June 20, 1780, cited in Inventario of the Mobile, AGI, PC, leg. 170-B.
41. Contract to Luison Chastang, 1793, AGI, PC, leg. 538-A.
42. Jack D.L. Holmes, "The Role of Blacks in Spanish Alabama, the Mobile District, 1780-1813, "Alabama Historical Quarterly, XXXVII, No. 1 (Spring, 1975), 10-11.
43. Pay records, AGI, PC, leg. 538-A; Purisima Concepcion parish records, Chancellor's Office, Mobile, Marriages, fol. 13.
44. Pay records, AGI, PC, leg. 538-A.
45. 1815 Map of Mobile Chancellor's Office.
46. Records kept by Francisco Fontanilla for the hospital at San Esteban de Tombecbe, AGI, PC, leg. 688.
47. Nicolas Joseph Rapun, "Regulations for the internal, political and economic management of the Royal Hospitals," Havana, August 30, 1775, AGI, PC, leg. 569 This has been roughly translated by A.P. Nasatir, as "Royal Hospitals in Colonial Spanish America," *Annals of Medical History* (New York), Third Series, IV, No. 4 (1942), 481-503.
48. Ibid., 497-502.
49. Jack D.L. Holmes, Gayoso, the Life of a Spanish Governor in the Mississippi Valley, 1789-1799 (Baton Rouge: Louisiana State University Press, 1965), 133.
50. List of medicines needed for the royal hospital, November 7, 1793, AGI, PC, leg. 27-B.
51. Opinion of English surgeons in the case of Mr. Molina, Pensacola, May 30, 1781, AGI, PC, leg. 113, and reprinted in Robert R. Rea and Jack D.L. Holmes, "Dr. John Lorimer and the Natural sciences in British West Florida," Southern Humanities Review, IV, No. 4 (Fall, 1970), 366.
52. Schaumburgh to Major Thomas H. Cushing, Fort Stoddart, July 19, 1799, in Jack D.L. Holmes (ed.), "Fort Stoddard in 1799: Seven Letters of Captain Bartholomew Schaumburgh," Alabama Historical Quarterly, XXVI, Nos. 3 & 4 (Fall & Winter, 1964), 234-235.
53. Morales to Eslava, New Orleans, August 29, 1796, AGI, PC, leg. 581-B.

● Dr. Holmes, Louisiana Collection Series, 520 South 22nd Avenue, Birmingham, Alabama 35205.

Farewell with a full heart

Rabun H. Williams, M.D.

It has been a privilege to live in an era in which there has been more progress in the medical profession than in all of medical history. Medicine used to be called an "art" but with today's sophisticated laboratory equipment and experimental animal studies it is fast becoming a "science." However, in spite of our scientific knowledge, we must not forget that in the application of that knowledge, the "art" of medicine still enters in. You cannot have one without the other.

At the age of 12 I knew I wanted to be a medical doctor. My inspiration came from our family physician, Dr. Jim Bishop. His dedication to his profession and will power to help people greatly impressed me. He was one of those rare old-fashioned country doctors who never kept books or sent out statements.

Training • I already had some practical medical experience brought about by my job in a drugstore adjacent to Dr. Bishop's office. Since he did not have a nurse, I took his calls and helped him administer chloroform to set fractures or do minor surgery. He soon began to take me with him when he went on night calls out of town; I drove while he slept.

I often dropped chloroform when he delivered babies. The first time we reversed roles and I delivered the baby, I had attained the ripe old age of 14. I did not know then, of course, that I would eventually deliver more than 4,000 babies including one in the back of a pickup truck, one in a chicken coop — the patient had been told this setting would help ease her pains — and one at the Jacksonville Railway Station during the 1927 hurricane.

I read every medical book I could find even though I did not know the meaning of some of the words. Dr. Bishop did his best to explain them to me.

My formal schooling took place at Alachua High School (Florida), after which I attended the University of Florida for my premed training. In 1926 I was graduated from Tulane University School of Medicine in New Orleans. I served my internship at the Duval County Hospital at Jacksonville.

When I came home after my sophomore year at Tulane, I brought Dr. Bishop a secondhand microscope I had won in a poker game and tried to teach him how to examine blood smears for malaria and how to identify pus cells in urine. He was very proud of his microscope and showed it to all his patients. I found out later that he diagnosed almost everyone in town as having malaria because he thought the polymorphonuclear leukocyte represented malaria. However, he wasn't far wrong because, according to the State Board of Health, at that time 50 to 60% of the population did have malaria.

My only taste of fame was when I delivered the first twins postmortem. In March 1927, while I was still an intern at Duval County Hospital, the home for wayward girls sent in a young lady in active labor, very obese, with generalized edema, and in convulsions. It was in the early hours of the night so I called Dr. Starlingworth, chief of obstetrics. He told me to give her an injection of magnesium sulfate, saying that it was something new for convulsions of toxemia of

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pregnancy. I immediately obtained the medication, which had been previously prepared by the pharmacy and autoclaved in the operating room. When I injected about half the solution, the patient went into respiratory depression and died.

I thought I might be able to save the baby, not knowing, of course, that there were two of them. The nurse rushed to the operating room but it was locked so she had to go to the nurses' sleeping quarters for the key. It was 12 minutes before she returned with the instruments.

I quickly did a cesarean and delivered two live baby girls, which did require a lot of suction and resuscitation. We had no oxygen available.

At that time, there was no record of twins having been born under these conditions. Nine years later a doctor in a small town in Texas reported a similar case in the *Southern Journal of Medicine*.

Practice • In 1928 I came to Eustis, Florida, to enter practice with Dr. Chambers M. Tyre, with whom I worked until his death in 1975. We built the Eustis Clinic, which accommodated five or six doctors, across the street from the hospital in 1946. The building is now owned by Waterman Medical Center. I continued to practice after Dr. Tyre's death until I retired from active duty in December 1982.

During that period of more than five decades, I saw many changes in the medical profession. For example, when I came to Eustis in 1928, there were about ten physicians in the Lake County Medical Society and no hospitals in Lake County. The nearest hospitals were in Orlando, 30 miles to the south, and in Ocala, 40 miles to the north. When a patient needed hospitalization, we put him in the back seat of our car and drove him to one of the hospitals.

We did tonsillectomies and minor surgery in our office and appendectomies and hernia operations in homes on the kitchen table. On one such occasion, Dr. Tyre and I were forced to shine the lights of an automobile through a kitchen window so that we might have light to perform an appendectomy. I might add that the operation was a success.

Although we did not make office appointments in those days, we saw everyone who came to our door. Dr. Tyre and I often examined as many as 100 patients a day; we always stayed until the last one had been seen.

During the throes of the Great Depression, we had to borrow money by giving our personal notes to finance the necessary equipment to operate the hospital. But we were not the only ones without funds. Many patients paid their doctor and the hospital in chickens, eggs, pigs, and produce.

I remember one fellow who had taken a third wife after the deaths of his first two. He had accumulated a family of about 15 children. Every Saturday he would get drunk on moonshine and by evening would feel as if he were dying. Dr. Tyre or I would go to his home and give a shot to calm him. Without fail he would always say, "Mary, go get the money to pay the doctor." And Mary would reply, "Jim, you damn fool, you know they ain't been no money in this house in three weeks." I don't think he ever paid us anything in cash but every autumn he brought us a winter's supply of syrup.

In those days office calls were a dollar; a house visit five miles away was three dollars and 50 cents was often accepted for an office visit. After World War II, patients were transferred to the hospital by the undertaker as there was no ambulance service; as a rule there was no charge for this.

Nowadays patients are transferred from the scene of automobile accidents to the hospital via ambulance for treatment. In earlier times a doctor was called to the scene. There was often very little we could do. The doctor's car usually served as ambulance and you can imagine the condition in which this left his vehicle. The next day he would remove the back seat, hose it down, and leave it in the sun to dry.

Many physicians thought they were privileged in such circumstances. They broke speed limits and if they were stopped by an officer they simply said they were a doctor.

A story circulated in Gainesville about a cattleman and one such doctor. Mr. "Cowman" was driving about 600 head of cattle down a prominent road when the good doctor had an emergency call and careened through the cows, blowing his horn and scattering them. Forty minutes later the physician returned to give a repeat performance, causing another near-stampede. Angered, Mr. Cowman approached the doctor's car and shot out all the tires. "I forgive you for coming through my cattle at such a high speed on the way to your patient," he said, "but I know durn well it is not necessary for you to hurry back." He then added, "Now, if you are not satisfied with what I've already done, I'll put one of these bullets through you."

There were very few specialists in the early 1900s. A doctor had to learn to treat everything the human body could be affected with. Now we have specialists within a specialty; no doctor can be proficient in all the diseases that affect a human being. It is wonderful that knowledge in the medical field has been disseminated throughout the world. I hope there will never come a time when knowledge will be patented and will not be given to the medical professions of all nations.

Also, there was no such thing as malpractice insurance until the early 1930s. My first premium cost $12 per year.

Paid advertising in the medical profession is commonly accepted today but Dr. Bishop found that word-of-mouth gave him more advertising than money could buy when Charlie Stevens, who lived

about five miles from town, choked on a chicken bone. His family called the operator and told her to get a doctor. She called Dr. Bishop.

The doctor's method of treatment would probably be considered unorthodox today, too. Dr. Bishop broke a small switch from a peach tree, scraped off the bark, secured a piece of rag over the end of it, greased it with butter, and passed it down Charlie's throat, dislodging the bone. Charlie did not fail to tell everyone in the entire community what a great physician Dr. Bishop was.

In looking back on the progress made in the medical profession, I cannot help but wonder what doctors of a hundred years ago could really do to help sick people. I believe it was Oliver Wendell Holmes who, about 1900, put it rather succinctly when he stated that if all members of the medical profession were drowned in the East River, he doubted if there would be an increase in the mortality rate.

There has been more progress in preventive and therapeutic medicine in the last 50 to 60 years than was made in any previously recorded history. Smallpox vaccine and anesthesia were developed. During World War II, the sulfa drug and penicillin were discovered, bringing about the control and practically the elimination of venereal disease. We have nearly wiped out typhoid fever, tuberculosis, poliomyelitis, smallpox, bubonic plague, cholera, and many other diseases.

But perhaps what doctors in earlier years lacked in scientific know-how, they compensated for in the "art" of humanity. A doctor was not a robot who hustled you in and out of his office; he was a friend and confidant who took time to discuss the taxes and the tulips. Families trusted their doctor and brought their troubles to him much as they would to their minister. Physicians did not charge other physicians and their families; neither did they bill members of the clergy. Doctors were more involved in family life than they are today.

In medical school we were taught medical ethics but no medical economics. It is difficult to put a finger on why medical costs have become so unreasonable, but I think we must take a look at greedy doctors, lawyers, and the injustice of some judges.

I cannot ever remember turning a patient away because he could not pay. The rewards may not have been monetary but they have been great nevertheless. Just a few days ago I was stopped on the street by a fine looking man of about 45. Recognizing me, he introduced himself thus: "You delivered me about 50 years ago in the back end of a truck. We never did pay your bill. My father, at that time, was in the penitentiary and we were poor."

In the final analysis, I am reminded of the story about an old doctor in a small town who died. After the funeral his friends gathered and decided they should get an appropriate marker for the grave. After much discussion, one of them said, "I know just the thing. Wait right here."

With that he left and returned in a few minutes with the sign from the steps leading to the good doctor's office. It read: "Dr. B.J. Smith, Upstairs."

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Hotel to hospital: update

Rabun H. Williams, M.D.

The Rowe Hotel was built in Umatilla, Florida, in 1924 but due to the collapse of the Florida land boom two years later, it stood empty and unused for several years. Mr. H.R.P. Miller of Eustis held the mortgage and offered it to the Florida State Elks Association which was interested in establishing a convalescent home for crippled children. This became the Harry-Anna Home for Crippled Children and was named for Mr. Miller and his wife, Anna. Only the south wing was used.

Members of the Lake County Medical Society saw the need for a general hospital and ten of the 20 physicians agreed to participate in its financial backing. They were Drs. W.L. Ashton, S.C. Colley, Raymond Conklin, J.D. Copeland, M.M. Hannum, H.C. Holland, Leroy Oetjen, C.M. Tyre, R.H. Williams, and W.L. Wood.

In January 1933, the Lake County Medical Center became a reality; it occupied the north wing of the Rowe Hotel with a capacity of 18 beds and six bassinets. All physicians in the county were given privileges for their patients.

After closing of the Fountain Inn Hotel in Eustis, Mr. Frank Waterman of the Waterman Pen Company offered the hotel to Dr. Tyre, his physician, and the Lake County Medical Center for a hospital. In 1938 the fourth floor was converted to a hospital with 30 beds, using the hotel beds for patients. Later an elevator had to be installed for Emergency Room patients as this care was provided on the upper floor. On July 1, 1938, the Lake County Medical Center moved into its new home, transporting 14 patients by ambulance.

The second floor was operated as a hotel with some of the employees living on the third floor. The building also included a bank, drug store, grocery store, barber shop, lady's shop and dentist office on the ground floor and at one time a bar occupied the mezzanine.

Fifty-two rooms had been renovated by 1963. The medical staff worked closely with the administration and a training program for nurses aides was established. Then came the survey of the hospital by the Joint Commission on Accreditation. An enlarged and modern kitchen of stainless steel and glazed tile was installed. Accreditation was obtained and has been maintained since that time.

By 1967 membership in the Association had grown to 1,400 and plans were made to enlarge the hospital with a $3 million building program aided by a $1,250,000 bond issue, plus federal Hill-Harris and mental health funds, totaling $1,022,120 in addition to the resources from the Association's building fund. A new addition was added and 34 private patient rooms were completed on the second floor north. The third and fourth floors were roughed in.

All donors giving $1,000 or more were privileged to belong to the "Golden Circle." The guest speaker for the 1971 dinner was Mr. Jack Monahan, Jr., executive vice president of the Florida Hospital Association. In his message he praised the hospital for the strides in improvement and stated that they were the greatest of any hospital in the state.

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Fig. 1—Fountain Inn, Eustis.

The bar, formerly on the mezzanine, is now used for a conference room, medical records, the Vincenti Memorial Library, and the "Pink Ladies" Lounge and classroom. There were other renovations at this time such as opening of an excellent operating room suite adjoined by a recovery room and intensive care unit, a large laboratory, cafeteria and dietary department, family room, nondenominational chapel, ultramodern x-ray facility, business and administrative office, snack bar, and lobby.

In 1974 the hospital assumed operation of the ambulance service with considerable improvement.

In 1975 the 43-bed medical/surgical nursing unit was opened on the fourth floor.

In 1977 the new obstetrical and nursery departments opened and Home Health Service was instituted to provide nursing and physical therapy in the home.

In 1978 a new intensive care and cardiac care unit were opened. This completed transformation of the entire fourth floor from the original hotel structure into a modern facility with the most sophisticated and up-to-date equipment available. In addition, the respiratory therapy department was enlarged; stress testing and pulmonary function equipment was installed, and it is now known as the cardiopulmonary laboratory. The latest in diagnostic imaging was installed in the x-ray department as well as equipment for the laboratory.

In 1980 the ambulance service received state certification as an advanced cardiac life support provider. Speech therapy was also established.

A new emergency room was opened in 1981. It was named in honor of Dr. R.H. Williams for his services to the hospital and the community.

In 1982 Lifeline, a 24-hour emergency assistance program, was offered to the residents of Lake County in addition to a new birthing room providing the ultimate in modern birthing trends.

And 1983, Waterman's 50th anniversary year, saw more changes. Automated blood analyzing equipment was installed in the laboratory and a million-dollar CAT (computerized axial tomography) scanner was added. A chaplaincy program also was established and the hospital purchased several parcels of neighboring property for future expansion.



Fig. 2—Waterman Medical Center, 1983, Eustis.



Fig. 3—Rowe Hotel, Umatilla.

The name Waterman Memorial Hospital was changed to Waterman Medical Center and a foundation was established. A certificate of need was received for Lake Hospice, Inc. to provide services for Lake and Sumter Counties. The Medical Center emergency department received certification as a level two trauma center.

Waterman did not stop there, however. A new laser machine for postcataract patients has recently been installed and, at the present time, a radiation-oncology center is being built and is expected to open in April 1984.

The hospital has expanded from 18 patient rooms and six bassinets to 153 beds and nine bassinets. The staff has grown from the original ten members to 46

staff physicians, 25 courtesy staff members, six members on the dental staff, and three honorary staff members.

We now have three other hospitals in the county, two in Leesburg and one in Clermont. Before the opening of the two hospitals in Leesburg, there were several small private hospitals to serve the northwest district.

Many old hotels have met their demise at the hand of a wrecking ball. Not so for the Fountain Inn! Community pride, dedication, service, and, yes, dollars, have given her a facelift, an internal tune-up, and a new name — Waterman Medical Center — a name of which we can all be proud.

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Fifty years of active medical practice

H. L. Harrell Sr., M.D.

I was graduated from Vanderbilt University School of Medicine in 1934 and interned for one year in Nashville, Tennessee, and for the next two years at Duval County Hospital in Jacksonville, Florida.

When I arrived in Jacksonville in 1935 to complete postgraduate hospital training the antibiotic era in medicine was just surfacing. Sulfonamides were used first during the last year of my residency. I witnessed deaths from cavernous sinus thrombosis, lateral sinus thrombosis, meningitis, septicemia from small furuncles, lobar pneumonia, and osteomyelitis, for none of which we had adequate treatment. For some unexplained reason we had not caught up with the value of immunization even for smallpox, tetanus and typhoid fever. All these diseases were present and somewhat devastating. We had typhus fever, dengue, malaria, amebic dysentery and undulant fever over the entire state. When I started practice in Ocala, I had several cases of diphtheria. I carried a tracheostomy outfit in my bag, sterilized, ready to use, together with tracheostomy tubes for intubation. I carried an ear knife to drain ears as the only really effective method then for treating otitis media. The undulant fever was practically epidemic because two of the three large dairies in Ocala refused to pasteurize milk and the chronically infected aborting cows from our adjoining northern states were being sold off to Florida to avoid health department rulings in their states. The dairymen there could sell them to us for more than the $25 a head which the government paid to destroy the cow.

We were told that children could not be raised in Crystal River because they invariably died of malaria and we were able to spot residents of Crystal River by the lumps in the buttocks from injected quinine. The anopheles mosquito did not move off Florida until after World War II. We had aedes also with dengue and falciparum malaria still present. Yellow fever had disappeared. With penicillin and sulfonamides arriving we had much better armamentarium. Later INH and PAS brought our widespread scourge of tuberculosis under much better control.

Physicians and practice • When I came to Ocala in 1939 everybody was still struggling with county income largely derived from WPA projects. There were 13 physicians in Ocala and I was to be the 14th. Most of them told me I was not needed and I soon found out they were right. Many of the sick people could not afford to pay and the good paying people were jealously guarded and protected from all new practitioners. An obstetrical patient could stay in the 75-bed Munroe Memorial Hospital with her new baby for ten days for $25 and very few could afford that. We did mostly home deliveries and naturally I got only the cases discarded by the older doctors. In spite of that, I averaged $10 an OB the first year (charge was $25) sometimes for a two days' and two nights' ordeal with a primipara at her home surrounded by all her female relatives and local granny experts. Competition was so strong that I was not allowed a rotation in our emergency room for the first year because of the few shekels gleaned from the

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unsuspecting tourists by the incumbent physicians. This prohibition of service was carried out in spite of my proof of training in the Duval County Hospital which probably led Florida in volume of emergency room service during those years.

Contracts with the local WPA setups were let to three of the older physicians which amounted to $30 to $60 a month to care for WPA workers and we younger physicians were not allowed on that exclusive roster. The few industries in the county already had their selected physicians and those practices were jealously guarded from infringement by the new interlopers. Fortunately there were two or three of the older physicians who would allow me to give anesthetics for their surgery or to fill in for them on weekends enough to help pay the grocery bill for my young family. I had worked in a lumber camp near Dade City for two years, had accumulated a meager bank account which barely lasted out the first year of my career in Ocala before the war.

The physicians present in Ocala when I came in 1939 were Drs. Eugene Peek Sr., H. C. Dozier, H. F. Watt, Robert Ferguson, James Chalker, Eaton Lindner, Ralph Russell, John Moore Sr., Richard Cumming, Tom Wallis and the colored physicians Nathaniel Jones and the Hughes, man and wife. Dr. Carl Lytle moved up a year later from Dunnellon. We had a 75-bed hospital, the Munroe Memorial Hospital (Fig. 1), built in 1928 of brick with a wooden building next to it serving as a nurses dormitory and school for nursing. Also, there was a hospital for colored people on Broadway operated by the Drs. Hughes, man and wife. I am not certain of its bed capacity. It was a large two-story wooden building. Dr. Ferguson and I did some surgery there in 1940. We would take turn-about doing the surgery and Dr. Hughes would give the drip ether anesthetic. Dr. Hughes always paid us cash as we left the hospital and Dr. Ferguson and I were guilty of fee splitting. We always split the proceeds right down the middle. I am fairly certain Dr. Hughes probably came out the small end of the horn on those deals. Our wooden nurses' home was later changed to a colored hospital before World War II and that gave us more bed capacity. There were no nursing homes. We now have four open and in use.

Marion Community Hospital with 135 beds was built ten years ago and has had one addition of 45 beds (Figs. 3-4). This was constructed and is still operated by the Hospital Corporation of America. The 75-bed Munroe Memorial has now become the Munroe Regional Medical Center (Fig. 2) and will have a capacity of 314 beds when the present addition is completed.

War • In 1940 there began rumors and rumblings of a future war and Herr Hitler changed things. Just when our local economy began to support my practice, I was drafted into the service. Dr. Cumming and I being in the army reserves were the first called, and both of us a year before Pearl Harbor. Dr. Carl Lytle and Dr. Ralph Russell were later called; and we all left just as things began to boom in Ocala. One physician was on the local selective service draft board and made what I think was a wise and just decision to allow the physicians who were reserve officers to be drafted first and very soon we were on our way to a five-year stint in some branch of the service.

For most of us the military service in World War II had for its good points an opportunity to travel at



Munroe Memorial Hospital - 1928

Fig. 1—Munroe Memorial Hospital built in 1928 — bed capacity 75.



Fig. 2—Munroe Regional Medical Center — bed capacity 314.

government expense, providing an educational and pleasant acquaintance with our own and foreign countries, complete relief from struggling WPA days, and fostering a genuine patriotism. Probably all wars waste personnel, lives and material and this one was no exception. So much of the physician's time and training was wasted that many of us wondered if we should not in some way pay back our army and navy salaries, especially the year before we became actually involved in the war where medical units were grossly overstaffed and inefficient.

After I became a field-grade officer and a unit commander I was often more involved with administration and court martials than in any semblance of the practice of medicine. This was even with my unit being a medical one. It is true many of us had our family life disrupted but supportive relatives helped tremendously to solve these difficulties. The physicians who stayed at home during World War II were often more heroic than we were in the service. One of our physicians, Dr. Robert Ferguson, I believe literally worked himself to death during the war and died of a heart attack soon after we returned. During those days physicians were markedly short in number particularly in small towns. Many of them had an almost unbearable load. At that time Ocala and Marion County villages were all small towns.

After the war • With the burgeoning economy following World War II, medical practice in Ocala flourished. For the next 20 years there was a gradual growth in the county and a gradual increase in physician population. Physicians were able to take care of a prosperous practice and still have enjoyable leisure. We had lived through the WPA days and had learned not to expect wealth overnight. I know of three Ocala physicians who lived and died in Ocala through the 30s and 40s and were never financially able to buy their own homes. That is in contrast to the present when the new physicians seem to be able to obtain unlimited credit and to even buy $200,000 homes without turning a hair. It is true that for the past 20 years Ocala and Marion County have grown at a prodigious rate. We have acquired practically all of the sophisticated specialties in medicine and support them well. Our hospital bed capacity has grown from 75 to 504 and we find ourselves frequently short. There were 34 members of the Marion County Medical Society in 1964. This had increased to 52 in 1973, and now in 1984 there are 128.

Being active in affairs of the Florida Medical Association after World War II, I was privileged to help organize Blue Shield and Blue Cross in the state and was a member of the original Blue Shield advisory Committee of Seventeen. Also, Drs. Henry Babers, Robert Zellner and I spent many hours together at each others homes in Gainesville, Orlando and Ocala working out the first fee schedule. At that time no committee expected to be paid expenses of any kind. I believe we should get back to volunteer work for our own organizations and charge less dues. That would be an item of cost containment.





Figs. 3 and 4—The present Marion Community Hospital — bed capacity 190.

With the advent of computers, by-pass operations, renal dialysis, and CAT scans, medical expense has assumed enormous proportions. Somewhere along the way we have lost the concept that mass production results in more efficiency and a cheaper product. All of our gadgets increase in price rather than decrease when more and more are used. Somewhere along the way individuals as well as corporations and governments must learn the necessity of a realistic budget. In our profession it should start with the individual, that is, with me and you.

In cooperation with the Marion County Commissioners, some of us have started a clinic for the county indigents manned by volunteer physicians, volunteer nurses and receptionists.

We are fast becoming a two-class nation — the wealthy and the welfare recipients. Our profession, as well as the others, needs to reestablish itself in a bourgeois middle class. We need to learn that we can enjoy life without the benefit of eye-boggling incomes. All of us need to realize that not everybody deserves an increase in income every year. Ascending inflation is no longer a viable excuse. Cost containment must be the name of the game or we will self-destruct just as some of our leading industries have done.

● Dr. Harrell, 1805 SE Lake Weir Avenue, Ocala 32671.

Disease and medicine among the pre-Seminole indians of Florida

William M. Straight, M.D.

> After this a little girl about four or five months of age fell sick, the niece of one of the leading gentlemen of the village, and they brought her to me so that I might say the Gospels over her; and I did so. And later, in as much as it seemed to me that she was very ill, we asked her father and mother in the presence of her grandfather and the old chief to make her a Christian and that they should not give her up out of fear, but rather so that she would go to heaven, if she should die. They gave her to me and I baptized her in the presence of the captain and the soldiers; and afterward I read the Gospels. And as her parents and grandparents loved her dearly and as it seemed to them that she showed no improvement, they called on the shamans, who worked many spells over her, pressing down on her body so that it seemed like they were kneading it. And as she was growing steadily worse the shamans said that if I had not touched her, they would have healed her. It was the Lord's will that she should die, and we buried her here in the fort, alongside a cross, . . . having first wrapped her in a shroud. And we carried her there singing the litany. I baptized her on the ninth of January and she died on the eleventh of the same month. The interpreter told me that if she had died under their law and if we had not been here, they would have killed four children with her . . .[2]

The site of this small human tragedy was on the north bank of the Miami River near its mouth. Today thousands of people walk over this area oblivious to the grief of this child's family, the efforts of Brother Francisco de Villarreal and the attempts of the Tequesta shaman four hundred years ago. Although of little consequence in the history of human life upon this earth, it gives us our earliest insight into the medical concepts of the natives who inhabited Florida when the Spanish began their settlements here.

The shaman • The tradition of the shaman or witch doctor was thousands of years old at the time this little tragedy took place. The shaman must have been one of the more imaginative, aggressive, articulate and pursuasive individuals of the tribe. He often wore several hats: priest, physician and sorcerer. The leader of the Huguenots who founded Fort Caroline on the bank of the St. Johns River in 1564, tells us:

> They have their Priestes to whome they give great credit because they are great Magicias great southsayers, and callers upon Divels. These Priestes serve them instead of Phisittons and Chirurgions. They carry alwayes about them a bagge full of herbes and drugs to cure the sicke diseased . . .

The Author
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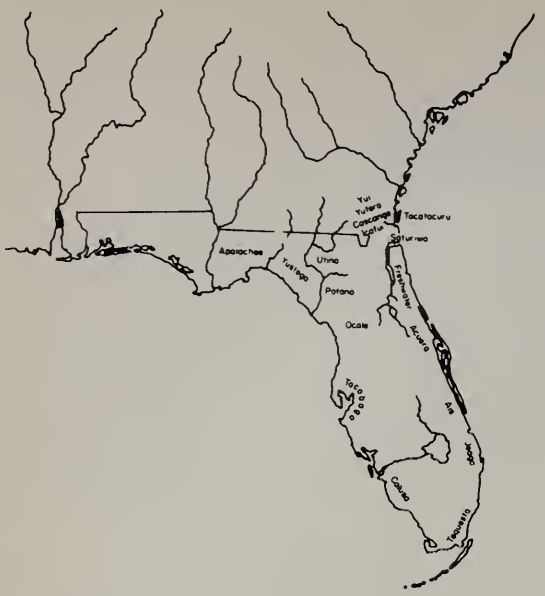


Fig. 1—Location of Indian Groups at the Time of European Contact[21]
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In the role of sorcerer or soothsayer the shaman was often called upon to predict the fortune of the coming battle. Thus in the drawing by Jacques Le Moyne[3] at Fort Caroline in 1564, the Timucuan chief, Outina, is pictured with his shaman who is performing a ritual to determine the outcome of a battle about to begin (Figure 2). This scene is described by Barcia:

> He presently directed a medicine man he had brought along with him to reveal the condition of the enemy and the forces they possessed. The medicine man was a frightful old man who might have been over a hundred and twenty years of age; he took a place in the center of the army and ordered Otigny's (commander of the French soldiers accompanying Outina's forces) buckler brought to him. This he placed on the ground and described around it a circle of about five paces in diameter; inside he drew various characters whereon he kneeled. Gradually he began to raise himself until he was sitting upon his heels, touching the ground with his toes only. He remained in that position for more than a quarter of an hour, talking to himself, grimacing and gesturing. Then he began to alter his aspect, turning into such a frightening figure that he seemed to have lost his reason. His agitation was so intense that his bones rattled as if they would break. In other respects, too, his behavior was abnormal. Consequently, he could not have been feigning. His actions could have been due to nothing else than the working of the Devil . . . The sorcerer began to come to his senses, and withdrew from the circle, so fatigued and wasted that he could not even breathe. He recovered somewhat and told the cacique the total number of the opposing army, as well as the place where it awaited him.[4]



Fig. 2—Outina Consults a Sorcerer[3]
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A Franciscan priest who lived among the Timucuans in North Florida early in the seventeenth century speaks of the shamans practicing black magic and distinguishes three magico-medical statuses: the herbalist, the doctor and the sorcerer.[5] Parja describes the shaman's technique: "In curing someone, have you placed in front of the sick person white feathers and new chamois and the ears of the owl and arrows which are stuck in, and then said that you will take out the evil and sickness?"[5] The priest suspected the Timucuan doctors of appealing to the Devil to obtain cures. He also suspected the doctors, herbalists and the midwives of witholding services or threatening the return of the disease if their fee was not paid. Herbalists and midwives were suspected of curing badly or witholding herbs that would speed the delivery until the patient paid a larger fee. By custom the patient having been cured must feed the doctor a cake made of acorn meal.[5] On his part the patient was expected to cook on a separate fire or they would die. At least at times they were taken to a special place by members of the tribe assigned to nurse them according to the French accounts. Pareja states the ill placed an offering of maize "to the Devil" in the door of the house to obtain a cure.[5]

A late description of a pre-Seminole Florida Indian shaman appears in the letter of a Franciscan priest, Father Joseph Xavier de Alana, from Tequesta in 1743.

> There is another Indian, whom they affirm to be a sorcerer and like God, terms which are synonymous for them. They con-

sult the latter concerning the future, the distant, what is to come; he also serves as the doctor for the place and his remedies are big bulky costumes ("grandes abultadas") and gestures that he makes over the sick person, covering himself with feathers and painting himself horribly. He is indeed a man who has in his visage I do not know just what trace (of being) a tool of the devil.[6]

Concepts of the cause of disease • Eons ago primitive man began speculating on the causes of disease. It was easy to explain the illness and death of a tribesman who was mauled by a saber-toothed tiger or penetrated by an enemy arrow, but what about those who just sickened and died? To explain these deaths the various Indian cultures of the New World arrived at strikingly similar thoughts. Among these are: soul loss, revenge of offended birds or animals, violation of taboos, the evil influence of women during their menstrual flow, sorcery, object intrusion, spirit intrusion and the effect of human or animal ghosts. Documentation for several of these beliefs has come down to us from the priests who lived among the pre-Seminole Florida Indians.

On the matter of soul loss as a cause of disease we are told by Father Juan Rogel who lived among the Calusas on Florida's lower west coast in 1568:

> They claimed that each man has three souls; one is the pupil of the eye, another one is the shadow that each one makes, and the other one is the image one sees in a mirror or in clear water, and when a man dies, they say that two of the souls leave the body, and the third one, which is the pupil of the eye, always remains in the body; . . . and when someone gets sick, they say that one of his souls has left and the witch doctors go to look for it in the woods, and they say they bring it back making the same movements that people go through when they try to put an unwilling wild goat or sheep in the pen. Later they put fire at the door of the house and the windows, so that it would not dare to go out again, and they report that they put it back in the man through the top of the head by conducting some ceremonies over it.[7]

Affronts to the birds and animals of the forest are also mentioned as a cause of disease. Father Pareja[5] implies the Timucuan belief that if a woodpecker sings the hearer will develop a nosebleed. To avoid this the hearer must remain silent while the woodpecker sings. If a "little goat" baas, a special herb must be put in the nose immediately else the hearer will sneeze and die. Also the hearer had to return to his home and bathe in "the water of the herb" to prevent dire consequences. As goats were not native to Florida, the editors of the Confessionario suggest that the designation "little goat" meant a young deer.

The pernicious influence of women during the days of their menstrual flow is a concept the origin of which is lost in the mists of antiquity. Readers of the Old Testament will recall the stringent laws of menstrual seclusion which are found in the King James version of the Holy Bible, Leviticus, Chapters 12 and 15. Because of similar menstrual seclusion customs, Timucuan women were required to cook at a separate fire and the food they cooked during their menstrual period could be eaten by no one except themselves. Laudonniere (1564) tells us: "And they eate not of yt (that) which they touch as long as they have their flowers (menstrual flow)"[8] Fifty years later Father Pareja[5] records the same taboos. Similar rules of seclusion applied to pregnant women; they must "light a separate fire."[5] Laudonniere also notes that a husband must not have sexual intercourse with his wife while she was pregnant.[8]

There is evidence that the Timucuans believed in object intrusion as a cause of disease; the Timucuan sorcerer is pictured by Pareja as sucking supposedly offending objects through the unbroken skin. Pareja believes that the sorcerer has previously placed in the palm of his hand "a little piece of coal, at other times a small lump of dirt or other unclean things," which he shows the patient after having sucked with his mouth on some part of the patient's body, and tells the patient he is cured. Pareja points out that this is impossible as the skin shows no opening from which the object could have come.[5]

Fear of the malign influence of the spirits of the dead is documented in the report of Father Joseph Xavier de Alana from Tequesta in 1743. He tells us: "They have a great fear of the dead, and, as a result it seems that they do not tolerate their being named, and daily they offer them food, tobacco, and herbs, covering the graves with mats and imploring them and even maintaining guards in the cemetery, and they go there often with processions, and they locate them at some distance from the village, out of fear, lest the deceased do harm to them."[6]

Diseases known to have occurred • Our knowledge of the diseases incurred by the pre-Seminole Indians of Florida is necessarily very limited. We are dependent upon "dry-bone" observations, paleopathology, from excavated mounds and the usually sketchy or unsupported statements of the French, Spanish and English who visited or lived in Florida. We can also speculate from our knowledge of food supplies and their customs of doing battle and from our knowledge of diseases prevalent among the Spanish settlers.

Arthritis and bone diseases • Up to the present time there have been only a few studies published upon the diseases revealed by the study of excavated Florida Indian remains. Among the most detailed of these studies is that of Snow who studied the remains of 115 individuals buried in the Bayshore Homes site, St. Petersburg, Florida. Congenital abnormalities, fractures of the extremities (rare), rib fractures in one instance, deeply worn teeth with apical abscesses and degenerative arthritic changes in the lumbar spine were found. Indeed "most of the older-aged adults" showed this degenerative osteoarthropathy. Many of the long bones showed "swollen, lumpy bone-tissue commonly associated with osteitis, periostitis and osteomyelitis." Several of the leg bones showed changes characteristic of syphilis.[9] Arthritic changes about the femoral heads were also described in remains from the Mayport Mound on Florida's upper east coast.[10] Finally, Larsen has carried out an extensive study of the remains of Indians of the Georgia coast comparing the findings in those of the pre-agricultural period (2200 B.C. to 1150 A.D.) with the findings in the remains of the mixed agricultural and hunting-gathering period (1150 A.D. to 1550 A.D.). Remains from the latter period showed an increased frequency of dental caries and periosteal reactions and a decreased frequency of degenerative joint disease. He concludes that a decrease in mechanical stress in the mixed agricultural hunter-gatherers and an increase in nutritional stress (less protein in the diet) account for these changes.[11] Another study of arthritic changes in skeletal remains compared remains of the Ais Indians to those of Coastal Eskimos. In the Ais the degenerative changes were more marked in the cervical and mid-thoracic spine while in the Eskimos they were most marked in the lumbar spine.[12] Morse has reported three cases of plasma cell myeloma (multiple myeloma) among Indian remains which were carbon dated between 500 and 900 A.D.[13]

Syphilis • Perhaps the most intense interest in Florida Indian paleopathology has been generated in the quest for an answer to the question of the origin of syphilis: Old World or New World? Early writers on this subject such as Oviedo[14] stated without hesitation that Columbus' sailors acquired the pox in the New World and took it back to Europe. Historically there were epidemics of syphilis around the time of Columbus' first voyage. Then too, for the first fifty years after the discovery of the New World the natives were considered subhuman beings and thus were a convenient scapegoat for a disease as disgusting as was the great pox.

The Huguenots[8] commented upon the sexual license they observed among the Timucuans:

> These Priestes serve them instead of Phisittons and Chirurgions. They carry always about them a bagge full of herbes and drugs to cure the sicke diseased which for the most part are sicke of the Pocks, for they love women and maydens exceedingly which they call the daughters of the Sunne . . .

Fifty years later Father Pareja and other priests were trying diligently to change the licentious ways of the Indians. Before marriage the girl was available to any male of the group and after marriage she may have been available to her husband's brothers, father and her godfather. By the same token her husband may have had sexual rights to her mother, sisters and his godmother.[5] Pareja also notes that women decorated themselves, perfumed their skirts, bathed in herbs and fasted to make themselves more attractive to the males. Polygamy was practiced by the Guale Indians of southeastern Georgia and the attempts by the Spanish priests to breakup this custom is cited as one of the causes of the Guale revolt of 1597. The leader of that revolt, Don Juanillo, addressing his followers complained: "They take away our women, leaving us only the one and perpetual, forbidding us to exchange her."[15] Judging from the questions asked of communicants by Father Pareja it seems likely that both male and female homosexuality existed as did also "boyish pederasty."[5] With all this sexual activity going on it seemed obvious that syphilis, a disease already recognized as spread by sexual intercourse, came from America.

Thus far no clinical descriptions of a disease suggesting syphilis among the Florida Indians has come to light. However, among the earliest paleopathological observations is the comment in 1922: "Next to massiveness the Florida bones from some localities impress one with the commoness of disease. This consists essentially of inflammatory processes, periostitis and osteoperiostitis, particularly on the tibia and other long bones. These lesions suggest strongly a syphilitic origin and it would seem that here if anywhere the problem of the presence of pre-Columbian syphilis in America could be settled."[16] Several other anthropologists have made similar observations, including Snow as we have previously mentioned, but the most complete and convincing evidence is presented by Adelaide K. Bullen. In her paper she cites evidence of syphilitic bone changes from several different mounds both on the Gulf coast and in northeast Florida. The specimens were examined by the section on bone pathology at the Army Institute of Pathology and felt to be leutic in origin. Whereas by carbon dating most of these specimens seemed to be from the period of 200 A.D. to 1500 A.D., specimens from the Tick Island Archaic site (on the St. Johns River in Volusia County) come from a much earlier period. Bullen concludes by saying: "Syphilis may have been present in a recognizable form as early as 3300 B.C. in Florida."[17]

Do these findings mean that Columbus' sailors did carry syphilis from the New World to the Old World? The answer to this question is, probably not. There is good evidence that syphilis existed in the Old World for many centuries before Columbus set sail. For those who wish to pursue this matter further, an excellent and up-to-date review of the subject is provided by El-Najjar.[18]

Epidemic infectious disease • Infectious diseases, which as we will see later devastated the pre-Seminole Indians of Florida, generally leave no trace in "dry bones." Although the very commonly found periostitis is viewed by some paleopathologists as evidence of infectious processes, these findings are not helpful in identifying epidemic disease. Therefore two methods have been commonly used in the effort to identify such diseases among the Florida Indians. One author in particular[19] has frequently identified disease outbreaks in Florida by presuming they represent the same disease then known to be present in Central America or the Caribbean Islands. He points to fairly solid evidence of contacts between the natives of Central America and the Caribbean Islands and the natives of Florida long before the Spanish arrived. However, most of our knowledge of epidemic disease among the pre-Seminole Indians is to be found in the documents of the Spanish occupation of Florida. For reasons set forth in the Notes and References of this article at the present time our knowledge is incomplete. The records now available sometimes document a disease by name and at other times merely identify it as a "peste." In the accompanying table the author has listed probable epidemics and the dates of their occurrence. In so far as possible the author has tracked these to their original document but space limitations make listing of each of these documents impractical.

Table 1—Epidemic Disease in Florida*
1570 - 1759

1570	? Malaria
1591	Unidentified pestilence
1597	? Measles
1613 - 1617	? Bubonic plague
1649 - 1650	Yellow fever or typhus
1654 - 1655	Smallpox
1657 - 1659	Measles
1672 - 1675	Unidentified pestilence
1727 - 1728	Unidentified pestilence
1732	Smallpox
1735	Smallpox
1758 - 1759	Smallpox

*In the Spanish documents currently available in Florida there is convincing documentation for the above listed epidemics. Dobyns[19] lists other epidemics which to this author are much less securely documented.

Battle wounds • Perhaps the earliest known weapon of the Florida aborigines is the atlatl or throwing stick. This weapon hurled a shaft equipped with a stemmed projectile point or a socketed antler projectile point. An example of this has been found in Warm Mineral Springs in sediment dating 9,500 to 10,500 years ago.[20] Bullen found three burials at the Tick Island site (3500 B.C. to 3000 B.C.) with stemmed projectile points sticking in the skeletons suggesting the atlatl was used in warfare as well as hunting.[21]

Just when the bow and arrow appeared in Florida remains a question. Cushing who uncovered one of the most complete finds of Florida Indian artifacts at Marco Island in 1896[22] found atlatls, arrows or spears likely thrown by the atlatl, war clubs, and dirks or stilettos but no bows. However, the dating of the Cushing artifacts is a matter of dispute. A conservative opinion is that they date from 500 A.D. or later; possibly as late as 1600 A.D. A currently accepted date for the arrival of the bow and arrow in Florida is about 800 A.D. and there is evidence of this weapon in North Florida as early as 400 A.D.[23] By the time the conquistadors began their marches through Florida the Indians were using the bow and arrow very effectively. The brother-in-law of Pedro Menendez de Aviles, founder of St. Augustine, tells us ". . . they shoot their arrows with such force that they pass through the soldier's clothing and coats of mail, and the Indians are very quick in shooting."[24] Oviedo[14] records that the Indians of Panama poisoned arrows with manchineel, but although manchineel grows in Florida, Swanton[25] states the Timucuans did not use poisoned arrows. No record of other Florida tribes using poisoned arrows has come to light.

Another weapon of the Timucuans was long fingernails. Le Moyne[3] the artist with the Huguenot colony, Fort Caroline (1564), tells us: "They also let their finger and toe nails grow very long, filing them along the sides so that they are made very sharp. But the men do this especially, for if they can catch one of the enemy, they drive their nails hard into his face, tearing away the skin, and leave him blind and mutilated." Le Moyne's drawings show Timucuan warriors carrying scalps and dismembering presumably dead enemies with knives made of reeds but it is not clear whether scalping was accomplished and the enemy allowed to live.

Before leaving the subject of battle wounds we must mention a class of Timucuans who were designated by the French as "hermaphrodites." Figure 3 is reproduced from Le Moyne and depicts the work of these hermaphrodites. In the commentary for this drawing Le Moyne[3] writes:

> Hermaphrodites, who share the attributes of both sexes, are common there, and are detested even by the Indians themselves; and yet, because they are strongly built and



Fig. 3—The Duties of the Hermaphrodites[3]
Reproduced by permission of the Trustees of the British Museum.

> vigorous, the latter make use of them in their work like draught animals for carrying loads. So when the chiefs go out to war the hermaphrodites carry the provisions; and when an Indian dies of wounds or disease it is they who will fit sticks across two sufficiently rigid poles and tie them to a mat woven out of thin rushes, on which they lay the body, putting a skin under the head and tying a second on the stomach, a third on the hip, and a final one on a leg (I did not inquire why they do this but I think it is done for show, because some individuals they do not adorn in this way but merely bind the legs). Then they take a leather strap three or four fingers wide and, with the ends of this fastened to the poles, they put the middle over their heads which are very strong and in this way carry the dead to the burial place. When people contract some infectious disease they also are carried by the hermaphrodites on their shoulders to specified places and taken care of by them and provided with necessities until they are fully restored to health.

It is very doubtful that the "hermaphrodites" were indeed true hermaphrodites or even pseudohermaphrodites anatomically speaking. It is much more likely they were "berdaches," male transvestites or homosexuals who assumed the dress, role and status of a woman, and were accepted in the tribe as such. From the above quote it appears that, among other duties, they served as nurses for the sick. Another very interesting point which is emphasized by Dobyns[19] is the apparent recognition of the concept of contagion by the Timucuans. Dobyns believes this constitutes strong evidence that the Indians of Florida had become closely acquainted with contagious diseases long before the coming of significant numbers of Europeans.

We are told the Indian women warmed piles of moss and used this instead of bandages to dress the wounds of an Indian warrior.[26] Nicholas Monardes, the physician of Seville who published a book on remedies from the "Newe Founde Worlde" in 1577, extolls the virtues of a balsam in the treatment of wounds:

> The Balsamo is verie common: and a used remedy for wounds being newe, for that it doth cure them by the first intention, glewyng together the partes without makyng matter, and where there be brewses that cannot be glewed together, it doeth a verie good woorke, making his digestion with redines, and the rest of the woorkes that doeth appertaine to Surgery, it doeth that whiche is convenient untill the woundes bee whole, and for this cause the use thereof is a common Medicine in all Surgery of poore folkes.[27]

Tattooing sickness • Another type of wound albeit voluntarily inflicted, was tattooing. The Timucuan chief and his wives were extensively tattooed over the face, trunk and extremities, as is pictured by Le Moyne. He tells us: "The reader should remember further that all these rulers and their wives decorate the skin of their bodies with a kind of tattooing in imitation of various painted designs (as he can see from the plates), and in consequence from time to time fall ill for seven or eight days. Nevertheless, they rub the places that have been pricked with a certain herb which adds an indelible stain."[3]

Childbirth and abortions • Still other causes of illness and death visited the Florida aborigines. At least one female skeleton with fragments of an infant skeleton within her abdominal area has been found.[43] This suggests death in childbirth. As we have seen the Timucuan women were attended at childbirth by doctors or midwives and Pareja mentions the use of "the herb" (possibly cassina) and prayer to assist in delivery.[5]

Perhaps deaths also occurred with attempted abortions. Father Pareja tells us Timucuan women and sorcerers produced abortions by a blow on the abdomen, herbs or by the sorcerer frightening the woman. He also mentions attempts to kill the unborn child by drinking something, squeezing the abdomen to choke the child, by lying on the bed improperly and putting an arm on top of the abdomen to suffocate the child.[5] The editors of the Confessionaria tell us abortion was customary in extramarital pregnancy. The herbs used to speed delivery or produce abortion are not identified.

Another possible cause of illness among pregnant and suckling women is a custom described by Le Moyne and illustrated in his drawing of how they

treat the sick. After explaining the incising of the forehead of the sick patient, the sucking of the blood from the incision and spitting the blood into a jar, he tells us: "Women who are nursing male babies or who are pregnant come to drink this blood, especially that of any powerful youth, so that their milk may be made more nutritious and the boys brought up on it may turn out braver and more vigorous."[3]

Forced labor on the Castillo de San Marcos • Another cause of the Florida Indian attrition was the forcing of the Indians to work on the fort at St. Augustine. As in other Spanish colonies natives were impressed to do the hard labor and as in other Spanish colonies, large numbers of them died. Finally, as in other Spanish colonies priests cried out against this practice. Father Pareja in January, 1617, wrote to the King: "The usual reason why so many Indians perish is that being relatively few they are unable to provide an adequate source of labor and therefore they are habitually required by the *presidio* to perform forced labor, such as rowing canoes or bearing loads overland, strained by the burden of so much work, waste away and die."[28] Fifty-six years later Father Antonio Somoza, writing about Santa Elena (near the present-day Hilton Head, S.C.) protested the forcing of Indians to go to St. Augustine to work on the Castillo de San Marcos, and states: "As the Indians are weak (by nature), the work continual and food in short supply, many die. . ."[29] Finally, the number of Indians became so few that the work on the fort was hampered. At this point the interim governor of the Spanish colony requested that the Queen send black slaves to replace the Indians who were working on the fort.[30]

Sacrifice and suicide • Another source of mortality was the Indian custom of sacrifice. LeMoyne tells of witnessing the Timucuan custom of sacrificing the first-born son to the chief. (Figure 4):

> It is their custom to offer the first-born son as a sacrifice to the chief. On the day appointed for the sacrifice he goes to the place set aside for the purpose, where there is a bench for him to sit on and, in the middle of the space, a tree trunk two feet high and the same distance across. Squatting on her heels in front of this and covering her face with her hands, the boy's mother bemoans her son's death. Her principal friend or relative offers up the boy to the chief in veneration. Then the women who have escorted the mother form a circle and dance, singing with joy but without joining hands; and the one who is holding the boy dances her way into their midst, praising the chief with some song. Meanwhile, six male Indians, who have been chosen for this duty, stand separately in a certain part of the area, the middle one among them, as executioner, holding a club with some ceremony. On completion of the rituals the executioner takes hold of the infant and slaughters him on the wooden trunk in front of the chief and all present. A sacrifice of this sort was carried out once in our presence.[3]



Fig. 4—The Sacrifice of the First-Born Sons[3]
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In 1961 Douglas F. Jordan excavated a mound east of Jacksonville on the east bank of Mill Cove and south bank of the St. Johns River. In it were found the skeletons of several children whose skulls had been smashed as one might expect if they had been sacrificed as described by Le Moyne. Thus we seem to have archeological documentation for the scene depicted in Le Moyne's drawing.[31,32]

As we saw in the opening paragraph of this article, Father Francisco de Villarreal described the custom of killing four children at the death of the daughter of "the leading gentleman" of the Tequestas in 1568. An anonymous writer of 1569 tells us that when the son of a Calusa chief (cacique) died "each neighbor sacrifices his sons or daughters who have accompanied the dead body of the Cacique's son." He goes on to tell us that when the chief or his wife died every servant of the chief or his wife, as the case might be, was put to death.[33] As late as the summer of 1743, the Keys Indians and their enemies, the Santaluzes, made peace and to celebrate the solemnity of the occasion, the chief of the Santaluzes planned to sacrifice "a little girl." Fathers Jose Maria Monaco and Jose Xavier de Alana learned of this and successfully interceded with the chief of the Santaluzes saving the child's life.[34] Suicides occurred among the Timucuans, especially the chronically ill. Hanging or taking an herb (which herb is not specified) were the commonly used methods.[5]

Alcohol and pica • Another cause of deaths in childhood was drunken fathers. Alegre in the reference just cited mentions in speaking about the children, ". . . their drunken fathers killed many of them before the use of reason . . ."[34]

Laudonniere speaking of the Timucuans mentions, ". . . in necessity they eat a thousand riffraffs, even to the swallowing down of coal and putting sand into the pottage that they make with the meal."[35] This custom is known as pica and may be a symptom of iron deficiency anaemia. Immediately one thinks of hookworm (Necator americanus) but that parasite is supposed to have been brought to the New World from Africa by the slaves. Perhaps the supposition is incorrect. There are other causes of iron deficiency anaemia of which pica is a symptom: dietary deficiency of iron, rapid growth in children on a diet marginally adequate in iron, poor iron absorption as in chronic diarrhea and in conditions of chronic iron loss as in severe menstrual loss or gastrointestinal bleeding. Finally, pica might have been a manifestation of a psychiatric disorder or just a method of filling the belly when food was scarce. As late as 1612, Father Pareja asks his parishioners: "Have you eaten charcoal, or dirt, or bits of pottery, or fleas, or lice?"[5]

Joyfull newes from the New World • In the next several paragraphs we will talk about the herbs used by the Indians who met the French and Spanish. Most of this information relates to the Timucuan Indians as they were the tribe most intimately known to both the French and Spanish. From the finding of certain bowls and dippers in burial mounds we can deduce a small amount of information. From our knowledge of the flora and of the medical practices of the successors to the pre-Seminole Indians we can surmise what herbs and plants may have been used medicinally, although we have no assurance they were so used.

The Black Drink • The best known of the Indian ceremonial and medicinal teas is the Black Drink (also known as: cassina, casseena, cacina, apalachine and apalachina) usually made of Yaupon holly (*Ilex vomitoria* Ait.) although on occasion when this was not available other varieties of Ilex were used. The leaves of this plant were roasted then steeped in boiling water to produce a drink which has a caffeine content similar to that of today's coffee or tea. It was the drink for certain ceremonial and social occasions, but it also served as a medicine to improve physiological and psychological well-being and possibly to produce emesis. We are told by the monk, San Miguel, who lived among the Guale Indians in the Sixteenth century:

> . . . these Indians and the Spaniards drink it in the morning and they say that it is of benefit against the stone, and that because it makes him urinate no Indian has that disease . . .[35]

Another early writer mentions its use for diseases of the chest, a hemostatic agent, to strengthen the stomach and to "allay the pains of the womb."[36] A Spanish prelate tells us:

> . . . the greatest gift (which one can receive from the Indians) is one that they make from an herb which is found along the seacoast which they cook and drink hot and which they call *casina* that is extremely bitter and is worse than beer although it is not intoxicating and has a beneficial effect.[37]

The drinking of the Black Drink is a custom that was widespread among the Indians of the Southeast. As the Yaupon holly grows best in the coastal marshes it was most widely used in and near the Atlantic and Gulf coasts[38] however, it was also used far inland being obtained as a trade item. Just when the custom began is not known but conch-shell drinking cups of the kind later used for the Black Drink have been found in burial mounds of perhaps as early as 100 A.D. in Florida.[21] As we have seen it was a well ingrained custom upon the arrival of the French and Spanish in the mid-sixteenth century. The Spaniards became addicted to it[39] and later the people of the Southern States drank cassina socially and medicinally, especially during the privations of the Civil War.

Perhaps the second most well-known medicinal from Florida's first Spanish period is sassafras *(Sassafras albidum* var. *molle)* called by the Indians "pauame." It is said the Indians taught the use of the root of this tree to the Huguenots who in turn told their captors, the Spanish, about it. Dr. Monardes devotes several pages to extolling the virtues of this sixteenth century wonder drug. In the sixteenth century English translation he tells us:

> . . . these soldiours doeth trust so muche in this woodde, that I beyng one daie emongest many of them, informing my self of the thynges of this Tree, that moste parte of them tooke out of their pokettes, a good peece of this woodd, and said; Maister, doe you see here the woodde, that every one of us doth bryng for to heale us with all, if we do fall sicke, as we have been there: and thei began to praise so muche, to confirme the mervelous workes of it, with so many examples of them that were there, that surely I gave greate credite unto it, . . .[27]

Monardes tells us to begin with that sassafras is "for all maner of deseases, without makyng exception of any," then one by one he lists the diseases in which it is useful. It is good for "Opilations (obstructions) in the interiour partes," and Dropsies. It is a cure for the Tertian and Quotidian Agewes, stimulates the

appetite and comforts the liver and stomach. It relieves the headache and toothache and the "griefes of the breast caused of cold humors . . . It doeth consume moysture and fleames . . ." It causes stones that are in the Raines to be cast out, but he warns that for stones in the bladder "onely the Surgions Raser . . . dooeth profite" when the stone is large. It heals them "that bee lame or creepelles" and cures the Goute and "evill of the Joyntes." "In the evill of Poxe, it doeth the same effectes that the reste of the water of the holie woodd, the China, and the Sarcaparillia dooeth . . ." It is useful "in the with holdyng of the Monthly custome that commeth not to women," and to stimulate fertility. Daily drinking of sassafras water will protect from "Pestilent and contagious deseases," and "Many did use to carrie a peece of the Roote of the wood with them to smell to it continually, as to a Pomander. For with his smell so acceptable it did rectifie the infected ayre . . ." The good-doctor goes into great detail about preparing sassafras water by "seetyng" (boiling) preferably the root of the sassafras tree but, if that is not available, the "Rinde" will do. He gives the dosage for various diseases and whether it should be taken hot or cold, fasting or non-fasting. He warns against failing to follow his directions and gives case reports to show the miraculous results of this medicine.

More famous as a "recreational drug" but used by the Timucuans, French and Spanish as a therapeutic drug is tobacco (Nicotiana rustica) also known as: tapaco, tabaco and petum in ancient writings. The chronicler of the English navigator, John Hawkins, who stopped at Fort Caroline in 1565 says:

> The Floridians when they travell, have a kind of herbe dried, who with a cane and an earthen cup in the end, with fire, and the dried herbs put together, doe sucke thorow the cane the smoke thereof, which smoke satisfieth their hunger, and therwith they live foure or five dayes without meat or drinke, and this all the Frenchmen used for this purpose: yet do they holde opinion withall, that it causeth water & fleame to void from their stomacks.[40]

Le Moyne[3] has left us a drawing of how the Timucuans used tobacco to treat disease. This is reproduced in Figure 5, right-hand figure. His description of this proceedure is:

> For the others, who lie on their stomachs, they prepare fumigations by throwing some seeds over burning coals. For when the fumes are taken up through the mouth and nostrils they spread throughout the whole body and induce vomiting, or drive out and destroy the cause of the illness. They also have a certain plant, whose name escapes me, but which the Brazilians call *Petum* and the Spaniards *Tabaco;* they put its well dried leaves into the broader part of a pipe, and when these are burning, they inhale the smoke so strongly, with the narrow part of the pipe placed in the mouth, that it comes out through their mouth and nostrils, and by this process it freely draws out the morbid fluids.

Tobacco was also considered the treatment for: ". . . all olde Soares, and cankered Ulcers, hurtes, Ringewormes, greate scabbes, what evill soever bee in them, in stamping the leaves of the said hearbe in a cleane Morter, and appliyng the hearbe and Joyce together upon the griefe, . . .[27]

Another plant used by the Indians and subsequently by the French and Spanish is the sarsaparilla (*Smilax tamnoides* and *Smilax glauca* primarily) which is also known as; Esquine, China and China-Root. Monardes discusses this plant and recommends it for: "Any maner of Reumes or Runnynges or Windinesse, the evil of women, of the mother, or any other cause or occasion whatsoever, so that it be not in fevers or other sharp deseases . . ."[27] As we have seen he also recommended it for the Poxe (syphilis).

The sovereign remedy for the Poxe however, was the "holie woodd." This is mentioned under the names guaiacan and guaiacum but is botanically known as *Guaiacum sanctum L.* The tree from which the oily infusion is made is known as the lignum vitae and is native to the Florida Keys, many Caribbean Islands and Central America.[41] Indeed, according to Dr. Morton this oil is still used in the Yucatan by the Indians to combat syphilis. It is also used for gout, rheumatism and gonorrhea by natives throughout its area. Of the value of the holie woodd Monardes tells us:

> A Spanyarde that did suffer greate paines of the Poxe, whiche he had by the companie of an indian woman, but his servaunte beyng one of the phisitions of that countrie, gave



Fig. 5—The Treatment of the Sick[3]
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> unto hym the water of Guaiacan, wherewith not only his greevous paines were taken awaie, that he did suffer but healed verie well of the evill . . . most certainlie it healeth and cureth the saied desease . . . without turnyng to fall againe, except the sicke man doe returne to tumble in the same bosome, where he tooke the firste.[27]

Still other remedies were learned from the Indians and utilized by the French and Spanish. Ribault, the French captain who lead two expeditions to Florida (1562 and 1565), mentions "roots like rinbabe (rhubarb)" as a medicine used by the Indians.[25] Another highly prized remedy was the Beads of Santa Elena. The precise identity of this plant is in doubt but it was likely a relative of the galanga or galangal and grew profusely in the marshes around Santa Elena, now Hilton Head, S.C. We are told the Indians used the herb to rub their bodies when they bathed and that it tightened the flesh and invigorated them. It was also used as a powder for the stomachache.[4]

Although not an herb another medicinal of great value from Florida was ambergrise. This waxey substance which is formed in the intestines of sperm whales, was gathered by the Indians and used to anoint themselves because of its pleasant aroma. It had been in use in Europe before the discovery of the New World and Monardes tells us that in the sixteenth century good "Ambar Grise" was worth twice as much as gold. In medicine it was used as a binder in pills, powders and confections and it also: took away the "greef of the hedde," comforted the "Senewes," opened the understanding and improved the memory, was "veri profitable to them that be Melancolie for it maketh them very merie," protected against pestilence and corrupt airs, and was good for the "Faulyng sickness" (epilepsy) and for "the Palseye" among many other things.

As these medicinals from the New World became popular in Europe a brisk trade grew up between Spanish Florida and French traders. This caused Spain great headaches as it divided the natives into Hispanophiles and Francophiles and thus led to prolonged wars.[42]

Numbers, stature and longevity • Until very recently Florida historians have estimated the number of Indians living in Florida when the French and Spanish first settled here at 10,000 to 15,000. Recent investigators believe this number far too few. Milanich and Fairbanks[21] state that at that time, "more than 100,000 Indians inhabited the state." A much more detailed examination of this question appears in Dobyns[19] and he arrives at approximately 150,000 Timucuan speaking Indians. By extrapolation he postulates the state as a whole had 722,000 inhabitants in the period of 1515 to 1520, the time of the first clearly documented European-Indian contact. Dobyns presents a convincing argument based on contemporary accounts (1564-1565) of the armies of different Timucuan speaking chiefdoms and of the size of their villages.

Although the French left detailed descriptions of the customs of the Timucuan Indians and Le Moyne left us drawings, we have no good descriptions of the stature of the Florida Indians. In the drawings of Le Moyne when comparison is possible the Indian chief appears considerably taller than the French commander, Laudonniere. Indeed, in the commentary that accompanies Le Moyne's drawing of the Chief Athore showing a stone column which had been left by Ribault, Athore is described as being at least half a foot taller than the tallest of the Frenchmen. In contrast the Indian soldiers seem to be the same size as the French soldiers. The Indian women are pictured as slightly shorter than the men. The facial features in the Le Moyne drawings have been Europeanized.

Another source of information about the stature of the pre-Seminole Florida Indians is the study of the remains of 115 individuals which were excavated by Sears.[43] Snow[9] who studied these remains concluded the males of those Indians averaged five foot six and a half inches tall and the females five foot four and a half inches. He concluded they had "strong, well-developed, muscular bodies."

The early accounts of the Florida Indians picture them as living "not lesse than two hundred and fiftie yeeres olde."[8] Snow's studies of the Bayshore Homes remains do not support these accounts. He found that 29.6% of the remains were children, 26.1% sub-adults and only 43.4% fully grown adults. Apparently nearly 80% died before reaching the age of 35 years. Snow notes that these statistics are similar to the information recently gathered by the World Health Organization for "almost all underdeveloped nations" in the world today which lack modern medical care. Willy[44] excavated 224 burials at Cockroach Key (three miles south of the mouth of the Little Manatee River) and noted that "over 50 percent of the burials were young children or infants."

Where did all the Indians go? • As we have previously noted, when the French and Spanish settled in Florida there were more than 100,000 Indians living in Florida. Indeed, if Dobyns' estimates are more correct there were eight times this number. What became of them?

Unquestionably the single most important cause of their disappearance was recurrent epidemic disease. Earlier in this paper we have listed these epidemics and the dates they occurred. It seems most likely that these epidemics were brought to the Indians by their contacts with Europeans. Although Juan Ponce de Leon is officially credited with the discovery of Florida in 1513, there are documented

visits of Spanish sailors to Florida as early as 1502.[45] There may have been trade between the natives of Cuba and Florida long before the discovery of the New World by the Europeans. Thus when the Spanish settled in Cuba they may have transmitted their diseases to the natives of Cuba who in turn transmitted these diseases to the Indians of Florida even before there was a significant presence of the Spanish in Florida.

Probably the first major contact of the Florida Indians with Europeans occurred with the explorations of Panfilo de Narvaez (1528) who was accompanied by 350 men, and the explorations of Hernando de Soto (1539) with 600 men. With the establishment of the Huguenot colony (1562 and 1564) and the Spanish settlement of St. Augustine (1565) intense and continued contact with the Indians began. These were the portals of entry that brought in diseases which devastated the Indians.

Another reason for the demise of the pre-Seminole Indians was interminable warring between the Indian nations and between tribes within one nation. There is evidence that at times the Spanish encouraged this when it suited their own ends.

As the pre-Seminole Indians decreased in number and strength by the middle of the seventeenth century, Creek Indians and others from what is now Georgia and Alabama began moving into North Florida.[46] This was the beginning of the Indians we know today as the Seminoles. Between 1702 and 1710, the British together with Indian allies systematically destroyed the Spanish missions and ranches across North Florida. They killed many of the Apalachee and Timucuans and drove the remnants to St. Augustine to the protection of the guns of the Castillo de San Marcos. Soon the Creek Indians fell out with the British and declared war on them. To escape punitive raids by the British and their still loyal Indian allies, the Creeks flooded into North Florida displacing the few remaining pre-Seminoles. Some of these tribes raided as far south as the Florida Keys destroying many of the remaining South Florida Indians. Finally, when Britain acquired Florida in exchange for Havana (1763), the small number of remaining pre-Seminole Indians, mostly clustered around St. Augustine and in the Florida Keys, left with the Spanish for Havana where some intermarried and some died.

It is thought that either a few remained around Charlotte Harbor[25] or possibly a few returned to Florida with the Spanish during the Second Spanish Period (1783-1821). During the Second Seminole War (1835-1842) there was a band of Indians known as "the Spanish Indians," who effectively raided army detachments and carried out the raid on Indian Key (May 7, 1840) in which Dr. Henry Perrine was killed. This band was led by an especially large, physically powerful and mentally bright Indian known as Chekika (Chakaika). It was generally thought that he and his band were descendents of the once powerful Calusa. In December, 1840, Lieutenant Colonel William S. Harney left Fort Dallas (at the mouth of the Miami River) with ninety men of the Second Dragoons and the Third Artillery in sixteen canoes. They surprised Chekika's band, killed six warriors including Chekika and took the rest prisoners.

This is the final mention of pre-Seminole Florida Indians in the pages of history although very likely some of their blood flows in the veins of today's Seminoles and possibly in the veins of some of the Cubans who have come to our shore in recent years.

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Notes and References

1. The Spanish Document Collection: A significant part of the source material upon which this article is based is the collections of Spanish documents from the first Spanish Period that are to be found at the P.K. Yonge Library of Florida History, University of Florida in Gainesville. At the request of the author, Mr. Paul L. Weaver with the help of his wife, Rosa Maria, searched all available finding guides for relevant material in the following collections: John B. Stetson, Woodbury Lowery, Jeanette Thurber Connor, Spanish Records of the North Carolina Department of Archives and History and the *Residencias* of Spanish Florida Governors. In addition many references to these collections that appear in other papers were sought and reviewed. All pertinent material not already available in a suitable translation was translated by Mr. Weaver. The quality and the quantity of material obtained was disappointing. This was not entirely unexpected for these collections are of documents concerned primarily with political, financial and administrative themes. In addition these documents were generated for the most part at top administrative levels and are thus necessarily general in scope and content. However, the few bits of information uncovered suggest that the Spanish did record information upon medicine and diseases among the Indians. Perhaps more of this information is available in the annual reports of the Franciscan priests *(cartas annuas)* which might be found in the General Archive of the Franciscan Order in Rome. Another possibility would be the archives of the Commissioner General of the Spanish Franciscan Order.
2. Letter: Francisco de Villarreal to Juan Rogel, January 23, 1568; Transl. by John H. Hann from Zubillaga, Felix S.J., Ed. Monumenta Antiquae Floridae (1566-1572), Rome, Apud "Monumenta Historica Societalis Iesu," 1946, pp.235-240.
3. Le Moyne de Morgues, Jacques: The Work of Jacques Le Moyne de Morgues, A Huguenot Artist in France, Florida and England, London, British Museum Publications Limited, 1977.
4. Barcia, Andres Gonzales: Barcia's Chronologic History of the Continent of Florida. From the year 1512, in which Juan Ponce de Leon discovered Florida until the year 1722. Translated by Anthony Kerrigan, Gainesville, University of Florida Press, 1951.
5. Pareja, Francisco: Francisco Pareja's 1613 Confessionario. A Documentary Source for Timucuan Ethnography, Ed. Jearld T. Milanich and William C. Sturtevant, Transl. Emilio F. Moran, Tallahassee, Div. of Arch., Hist. and Records Management, 1972.
6. Report which Fathers Joseph Maria Monaco and Joseph Xavier Alana of the Company of Jesus present to the Ex^{mo} Sr. D^{n} Juan Fran^{co} Guemes de Horcasitas, Lt.-General of the Royal Armies, Gov^{or} and Capt. Gen. of the City of Havana and of the Island of Cuba, concerning the state in which they have found the Indians of Southern Florida and its Keys, along with what they considered necessary for its permanent reduction. Translated by John H. Hann and found in: Letter and enclosures, Gov. of Cuba to the King, Sept. 28, 1743, AGI 58-2-10/15.
7. Lewis, Clifford M.: The Calusa, In Tacachale, Essays on the Indians of Florida and Southeastern Georgia During the Historic Period, Gainesville, The University Presses of Florida, 1978.
8. Laudonniere, Rene: A Notable History Containing Four Voyages Made by Certain French Captains Unto Florida, Edited by Martin Basanier and Translated into English by Richard Hakluyt. A Facsimile of the Edition Printed in London in 1587, Larchmont, N.Y., Henry Stevens, Son & Stiles, 1964.

9. Snow, Charles E.: Indian Burials From St. Petersburg, Florida, Contributions of the Florida State Museum, Social Sciences No.8, Gainesville, University of Florida, 1962.
10. Wilson, R.L.: Excavations at the Mayport Mound, Florida, Contributions of the Florida State Museum, Social Sciences, No.13, Gainesville, University of Florida, 1965.
11. Larsen, C.S.: Skeletal and Dental Adaptations to the Shift to Agriculture on the Georgia Coast, Current Anthropology: No.4, 422-423, August 1981.
12. Finnegan, Michael and Frayer, David: Current Research in Paleopathology, Colorado Anthropologist, III-2, 20-22, 1971.
13. Morse, Dan, Dailey, R.C. and Bunn, Jennings: Prehistoric Multiple Myeloma, Bulletin of the New York Academy of Medicine, 50: 447-458, April, 1974.
14. Oviedo, Gonzalo Fernandez de: Natural History of the West Indies, Translated and Edited by Sterling A. Stoudemire, Chapel Hill, The University of North Carolina Press, 1959.
15. Larson, Lewis. H.: Historic Guale Indians of the Georgia Coast and the Impact of the Spanish Mission Effort, in Tacachale, Jearld Milanich and Samuel Proctor, Editors, Gainesville, University Presses of Florida, 1978.
16. Hrdlicka, Ales: The Anthropology of Florida, Deland, The Florida State Historical Society, 1922.
17. Bullen, Adelaide K.: Paleoepidemiology and Distribution of Prehistoric Treponemiasis (Syphilis) in Florida, Florida Anthropologist 25: 133-174, Dec. 1972.
18. El-Najjar, Mahmoud Y.: Human Treponematosis and Tuberculosis: Evidence from the New world, Am. J. Anthropology 51: 599-618, 1979.
19. Dobyns, Henry F.: Their Number Become Thinned. Native American Population Dynamics in Eastern North America, Knoxville, University of Tennessee Press, 1983.
20. Clausen, C.J., et. al.: Little Salt Spring, Florida, A Unique Underwater Site, Science 203: 609-614, Feb. 16, 1979, See fn 12, p. 613.
21. Milanich, Jearld T. and Fairbanks, Charles H.: Florida Archaeology, New World Archeological Record, New York, Academic Press, Inc., 1980.
22. Cushing, Frank Hamilton: Exploration of Ancient Key Dweller's Remains on the Gulf Coast of Florida, Proceedings of the American Philosophical Society (Philadelphia) 35: 329-448, 1896.
23. Milanich, Jearld T., Personal Communication, 5/5/84.
24. Connor, Jeannette Thurber, Ed.: Pedro Menendez de Aviles, Memorial by Gonzalo Solis de Meras, A Facsimile Reproduction with Introduction by Lyle N. McAlister, Gainesville, University of Florida Press, 1964.
25. Swanton, John R.: Early History of the Creek Indians and Their Neighbors, Smithsonian Institution, Bureau of American Ethnology, Bulletin No.73, Washington, Government Printing Office, 1922.
26. Laudonniere, Rene: Three Voyages, translated by Charles E. Bennett, Gainesville, The University Presses of Florida, 1975, p. 81.
27. Monardes, Nicholas: Joyfull Newes Out of the Newe Founde Worlde, Written in Spanish by Nicholas Monardes, Physician of Seville, and Englished by John Frampton, Merchant, Anno 1577, with introduction by Steven Gaselee, New York, Alfred A. Knopf, 1925.
28. Letter: Francisco Pareja, et. al. to the King, St. Augustine, Jan. 14, 1617, SD 54-5-20/18, JTC 4, translation by Paul L. Weaver.
29. Letter: Antonio Somoza to the King, May 2, 1673, AGI SD 54-5-20/97, JTC 4, translated by Paul L. Weaver.
30. Letter: Interim Gov. to the Queen, St. Augustine, May 8, 1674, ST AGI 54-5-11/10 bnd 1884.
31. Jordan, Douglas F.: The Goodman Mound, Contributions of the Florida State Museum, Social Sciences, No.10, Gainesville, University of Florida, 1963, pp 24-49.
32. Bullen, Adelaide K.: Physical Anthropology of the Goodman Mound, McCormack Site, Duval County, Florida, Contributions of the Florida State Museum, Social Sciences No.10, Gainesville, University of Florida, 1963, pp. 61-70.
33. Anonymous manuscript, 1569, Caciques y costumbres de los yndios de la Florida With annotations by Juan Lopez de Velasco. AGI Sevilla Indiferente General, 1530 (145-7-9)
34. Alegre, Francisco Javier, S.J.: Historia de la Compania de Jesus en Nueva Espana que estaba escribiendo el Padre Francisco Javier al tiempo de su expulsion, 3 Tomes, Mexico, Imprenta de J.M. Lara, 1841-1842; Tome III., pp. 276-280.
35. Swanton, John R.: The Indians of the Southeastern United States, Smithsonian Institution Bureau of American Ethnology, Bulletin No. 137, Washington, Government Printing Office, 1946. Reprint by Greenwood Press, Publishers, New York, 1969.
36. Charlevoix, P.F.X. de, S.J.: History and General Description of New France, 1744, translated by John Gilmary Shea (1870), Chicago, Loyola University Press, 1962, Vol.I.
37. Letter: Bishop of Cuba to Antonio de Rozas: Havana, January 4, 1676 ST AGI 54-3-2/2 bnd 1958. Translated by Paul L. Weaver.
38. Hudson, Charles M., Ed.: Black Drink A Native American Tea, Athens, Ga., The University of Georgia Press, 1979.
39. Sturtevant, William C.: Black Drink and Other Caffeine-Containing Beverages among Non-Indians, pp. 150-165, In Black Drink A Native American Tea, Charles M. Hudson, Ed., Athens, Ga., The University of Georgia Press, 1979.
40. Hakluyt, Richard: The Principal Navigations Voyages Traffiques & Discoveries of the English Nation, Glasgow, James MacLehose and Sons, 1904, Vol. 1, p.57.
41. Morton, Julia F.: Atlas of Medicinal Plants of Middle America, Bahamas to Yucatan, Springfield, Charles C. Thomas, 1981.
42. Bushnell, Amy: The King's Coffer, Proprietors of the Spanish Florida Treasury, 1565-1702, Gainesville, University Presses of Florida, 1981.
43. Sears, William H.: The Bayshore Homes Site, St. Petersburg, Florida, Contributions of the Florida State Museum, Social Sciences, No.6.
44. Willey, Gordon R.: Archeology of the Florida Gulf Coast, Smithsonian Miscellaneous Collections, Vol. 113, Washington, The Smithsonian Institution, 1949, p. 163.
45. Milanich, Jearld T.: "Where Have All The Indians Gone," in Born of the Sun, Edited by: Joan E. Gill and Beth R. Read, Hollywood, Fl., Florida Bicentennial Commemorative Journal, Inc., 1975, pp. 40-49.
46. Milanich, Jearld T.: The Western Timucua: Patterns of Acculturation and Change, pp. 59-88, in Tacachale, Jerald T. Milanich and Samuel Proctor, Editors, University Presses of Florida, 1978.

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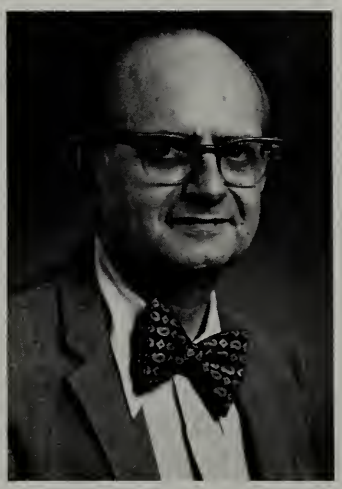
FLORIDA MEDICAL

DEPARTMENTS

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NOTES & NEWS

Lewis A. Barness, M.D., receives Goldberger Nutrition Award



Dr. Barness

Lewis A. Barness, M.D., Professor and Chairman of Pediatrics at the University of South Florida College of Medicine is the 1984 recipient of the Joseph B. Goldberger Award in Clinical Nutrition presented by the American Medical Association. He is the first Floridian to be so recognized.

Dr. Barness, a charter member of the College of Medicine faculty and a highly respected pediatrician, is well known for teaching and research in pediatric nutrition. He is recognized for many outstanding contributions, including the establishment of the minimum nitrogen requirements for infants and the effectiveness of vitamin E therapy in the management of certain hemolytic anemias in premature infants.

Dr. Barness has made exceptional contributions in pediatric nutrition through his role as a member and Chairman of the American Academy of Pediatrics' Committee on Nutrition. His many research papers and books, especially his book on physical examinations in pediatrics, attest to his qualifications for the Joseph Goldberger Award in Clinical Nutrition.

The award, which is presented by the AMA Board of Trustees, was named in honor of the late Dr. Joseph B. Goldberger who was chiefly responsible for the discovery of the cause and treatment of pellegra. It was established in 1949 and is bestowed every year that a deserving candidate is proposed. Recipients are selected by the Board of Trustees on the recommendation of its awards committee.

University of Miami receives $360,000 medical grant

The University of Miami, along with 14 of the nation's other leading research universities and medical schools, has been awarded a $360,000 grant from the Lucille P. Markey Charitable Trust for predoctoral fellowships in the basic medical sciences. The funds will be divided equally over a five year period between the departments of physiology and biophysics, and pharmacology, and may be used to defray stipends, tuition, research and/or travel expenses.

"In recent years, as the need for medical research fellowship funding has steadily increased, the amount of funding available has not kept pace, and this is particularly true for those just starting on their research career as predoctoral graduate students," said William P. Sutter, president and chairman of the Lucille P. Markey Charitable Trust Fellowship Committee.

"It is our hope that the supplemental funds being made available through this grant will enable selected students to pursue their studies more effectively by virtue of lessened financial burdens," he said.

Stanford University, Harvard University, Yale University, Massachusetts Institute of Technology, Johns Hopkins University, University of California at Los Angeles, and Northwestern University are among the other recipients of the grant, established under provisions of the will of the late Lucille P. Markey.

"The University of Miami School of Medicine is delighted to be among the selected group to be awarded these funds. The institutions receiving this award, to support predoctoral graduate students, are among the very best in the United States," said Dr. Bernard J. Fogel, Dean of the UM School of Medicine. "This award gives us the unique opportunity to strongly enhance two of our already outstanding basic science departments. We feel strongly that graduate education is extremely important to the development of a medical school, through the enhancement of its biomedical research programs."

Medi-file card available for elderly

A new wallet-sized card designed to help elderly Floridians keep track of the prescription drugs they are taking will be available from the Florida Medical Association soon. Called "Medi-File," the card was developed by the FMA Committee on Aging as part

of an FMA program promoting home health care and good health habits for older adults. The card provides ample space for entry of all prescriptions ordered for the carrier plus dosage instructions and the names of the prescribing physicians. Carriers are urged to present the card each time they seek health care. The cards will be distributed by the Florida Medical Association Auxiliary. Additional information may be obtained by contacting Mr. Edward D. Hagan, Director of Medical Services, Florida Medical Association, Post Office Box 2411, Jacksonville, Florida 32203, telephone (904) 356-1571.

Resident papers competition winners announced by Florida Chapter, American College of Surgeons

The recent annual meeting of the Florida Chapter, American College of Surgeons included its Second Annual Resident Papers Competition. Eleven papers were submitted and the following three winners were selected:

- "Jejunoileal Bypass for Morbid Obesity," by Michael P. Hocking, M.D., a surgical resident at the University of Florida College of Medicine
- "The Effect of Stasis on Microvascular Anastomosis," by Enrique J. Fernandez, M.D., a resident in plastic surgery at the University of Florida College of Medicine
- "Contribution of Nutrient Malabsorption to Weight Loss After Gastric Bypass," by John W. Robertson, M.D., a surgical resident at the University of Florida College of Medicine

Each of the winners received a $100 honorarium and travel expenses to attend the Florida Chapter Annual Meeting held in conjunction with the Florida Medical Association Annual Meeting in Lake Buena Vista on May 4, 1984. Each award winner personally presented his paper. The resident papers selection committee was chaired by H. Quillian Jones Jr., M.D., a practicing general surgeon from Ft. Myers. Other members included Richard C. Connar, M.D., Chairman, Department of Surgery, University of South Florida College of Medicine and Edward M. Copeland III, M.D., Chairman, Department of Surgery, University of Florida College of Medicine.

DEAN'S MESSAGE

Medical Malpractice — Dèjá vu

As we proceed with our public initiative for constitutional reform in November 1984, it is timely to consider the problem from a historical standpoint.

A doctoral dissertation in 1969 by C.R. Burns, M.D., for a Ph.D. degree from The Johns Hopkins University carefully reviews the medical malpractice atmosphere in our nation prior to the Civil War beginning about 1840.

One of the earliest references to medical malpractice in this young nation occurred in 1843 during a commencement speech by Frank H. Hamilton, M.D. to the new graduates of Geneva Medical College. He noted that within the previous two years, more than 20 charges of malpractice had been filed against "respectable and eminent surgeons" in New York State. Within a few years, the problem was so great that Professor James Webster at Geneva Medical College lectured to the class in anatomy about the high rate of malpractice claims. By the mid-1850s, other states such as Vermont, Massachusetts, and Ohio were experiencing an alarming rise in malpractice suits.

During the ensuing years, many state justices rendered opinions based on moral expectations of the public. They contended that a physician was responsible for what he professed he was able to do. If he claimed to be a member of the medical profession, he was responsible for "suitable education and training." Thus, the role of education became a prime requisite for competent medical practice several decades before the Flexner Report of 1910.

Also, the Massachusetts Medical Society prior to 1850 recommended that a "disinterested physician" serve as a mediator if a malpractice suit was contemplated or filed by an unhappy patient. This was probably the first consideration in this country of mediation panels.

It was further held, at that time, that judges and jurors were repeatedly confused because of conflicting medical testimony. In those years when medicine was at least as much an art as science, it is no wonder that such conflicts occurred since physicians professed to be medical scientists. The same situation occurs today with our expert witness testimonies.

As we continue to struggle with this crisis, it is of little comfort to know that the problem has been with us for over 140 years. As we enter into *Reason 84*, we need to be reminded that history is against

us. Therefore, we, both as physicians and citizens, need to work diligently to inform the public, as best as we know how, about this societal issue. We must make clear that this is not a patient *versus* physician issue or lawyer *versus* physician issue, but an issue that adversely affects all of society. Further, we must do so in a professional manner, with dignity and grace.

Finally, as George William Curtis said in his book, *The Call of Freedom*, "While we read history, we make history." Therefore, as we reflect on the past, let us make history on November 6, 1984.

William B. Deal, M.D., Dean
College of Medicine
Associate Vice President
for Clinical Affairs
University of Florida
College of Medicine
Gainesville

WORTH REPEATING

Are we physicians helpless?

In my lifetime, medicine and the illnesses we physicians are asked to treat have changed greatly. Many of the past scourges have gone, yet we seem to be faced not with fewer problems but with more and more. I will comment about some of these problems and then mention a few simple things each of us can do that will do no harm and, I believe, may even ameliorate a situation that is rapidly becoming difficult for each of us.

We have come a long way in bringing science into medical practice, but we still have a long way to go. In fact, medical science has only made a start, although a good one, in understanding how to prevent and treat disease. Smallpox is gone. The dreadful scourge of poliomyelitis is rare. We are rapidly beginning to learn much more about the biology of cancerous growth. Myocardial infarction is already declining in frequency, perhaps because of better recognition of risk factors. Modification of the genetic bases for some diseases may be available soon. These and other striking improvements in health are soon taken for granted by the public, but fortunately future physicians will have the opportunity to do much more than we. Problems loom, however, that if unsolved may make the practice of medicine more and more difficult. Problems such as high cost of care, diminished autonomy and independence of physicians, and public disenchantment with scientific and "high-technology" medicine are threatening future medical practice. Valid or not, the complaint is heard from all sides that doctors no longer care for patients but are interested only in diseases. I believe this is generally not true, but insofar as it is perceived to be true by patients and by commentators on modern medicine, our effectiveness as physicians is limited. We must consciously set about to reverse this faulty concept or change our ways to the extent that it may be true. The doctor's job is to care for people, not diseases.

The antiscientific attitude of many, especially of some groups of young people today, is illustrated by the growth of "alternative" systems of practice. The critical public must be helped to learn about the true usefulness of science. We, on our part, have a responsibility to see that the need for technology is understood by our patients and that we use it judiciously and with good effect in caring for people. The overuse of technical procedures for whatever reason is not good medical practice, and it adds greatly to cost and impairs the public's understanding that scientific medicine is a necessary part of medical care.

Another point. For many years we have been concerned about the prospect of government control. We now accept licensing and relicensing, but we have not been entirely happy with certain other government intrusions, and the latest "caps" to control costs are ominous signs. Nevertheless, as costs escalate we can expect more attempts at control.

The Harvard sociologist Paul Starr, in his recent treatise *The Social Transformation of American Medicine*, comprehensively discusses the changes in medical care in this country from the mid-18th century to the present, ending with a chapter looking into the future, entitled "The Coming of the Corporation."[1] Here he explores the recent growth of the for-profit corporations being organized to provide medical care, and he makes some predictions about their future growth. Some have taken offense, believing him overly critical of our profession, which I think is not the case. Whatever one's reaction to the book, I heartily agree with Dr. Relman, whose review in *Journal* states that physicians "can ignore its message only at their peril."[2]

Corporations and similar organizations as third parties coming between doctors and patients are, of course, not new. For example, Starr found that "In 1911, one Pennsylvania doctor remarked of lodge practice that 'the physician is being exploited for the benefit of the middleman; his services are purchased at wholesale and sold at retail.'" Other instances are not difficult to bring to mind. The point is that we physicians must be the ones to decide how we practice our profession. It is not going to be easy,

however, to remain in control. Many people are prepared to tell us how to do it. These include people in government and in businesses that are interested in controlling costs, the experts in resolving the "health-care crisis," and now members of the rapidly growing corporate entities. The independence of action that has been ours is threatened as never before. Yet we must allow interference with medical practice as little as possible. How can we accomplish this? I believe that the responsibility rests in large measure on our own shoulders and that we present-day physicians have the ability to make changes in the way we do things, in the way our profession is regarded, and in how much it all costs.

First of all, each of us must at all times practice the best caring medicine as well as scientific medicine. If we do so we will be seen by the public as doing so, and our strongest backing is a public whose members are receiving, and believe they are receiving, top-notch medical care. What do I mean by "caring medicine"? I mean having the patience, taking the time, and making the effort to listen to the patient. I mean thoroughness in the physical examination and careful consideration before tests or procedures are undertaken. Dr. Philip Caper[3] has expressed another aspect of caring:

> The process of caring for the patient, the interpersonal supportive and psychologic aspects of the physician-patient relation — is the component of quality that most frequently separates the fulfilled physician with a busy practice of satisfied patients from others. It is the factor which gives rise to satisfaction on the part of the doctor and the patient alike, accompanying and sometimes replacing the cure.

Our constituency is our patients. They will support us if we take the time and make the effort to provide them with the best medical care.

Secondly, our medical societies must be seen as gatherings of dedicated physicians planning improvements in care rather than as guilds opposed to all progress, as we are sometimes, I hope erroneously, pictured. In commenting on past problems of our profession, Paul Starr has said: "The profession's mastery of itself was the precondition for its mastery of public sentiment."

Thirdly, each of us must be cognizant of the costs of the care we provide and must help with its control by not overusing technology. Each of us must ask, "Is this procedure, this test, or this operation necessary?" In this connection, important recent studies have shown unaccountable variations in the number of hysterectomies among towns in Maine.[4]

We must also be reasonable in our own demands for recompense. Doctors deserve a good living but not an extravagant one. Greed and medical care are not compatible. We must take major responsibility ourselves for cost containment, not leave it to government or to corporations, or we will lose our independence.

Finally, we must see to it that all segments of our population receive good medical care. It is our responsibility not to allow two classes of care. A former president of the Massachusetts Medical Society, Percy Wadman, has called on us to do just this in a letter to members of the Society. This is among the oldest traditions of our profession. We must not forget it but must work personally and through our professional organizations to see that the benefits of scientific and caring medicine are available to everyone who needs it.

To conclude then, my message is that our armament in the battle for our profession's continued independence against outside control consists of our determination to see that the care we each provide is the best to be had, costs only as much as necessary, and is available to all. The public will respond with its support, and public backing is a powerful force — more powerful than any available to those who would control us. If we lose control of the way we practice our profession, both we and our patients will suffer. Much of the choice is ours.

References

1. Starr, P.: The Social Transformation of American Medicine. New York: Basic Books, 1982.
2. Relman, A.S.: Review of: *The Social Transformation of American Medicine*. N. Engl. J. Med. 1983; 308: 466.
3. Caper, P.: The Meaning of Quality in Medical Care. N. Engl. J. Med. 1974; 291: 1136-1137.
4. Wennberg, J. and Gittelsohn, A.: Variations in Medical Care Among Small Areas. Sci. Am. 1982; 246(4): 120-134.

Charles S. Davidson, M.D.
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Book Review Editor — **F. Norman Vickers, M.D.**

The Cancer Survivors and How They Did It

By Judith Glassman, 414 Pages. Price $17.95. The Dial Press, New York, 1983.

Judith Glassman's book on the cancer survivors is focused primarily on testimonial interviews with an unorthodox therapy described in detail. These alternative therapies emphasize that the body has the ability to defend itself against cancer and that the goal is to cleanse the body of what are seen as harmful substances and to stimulate its natural defenses. Such topics as "Diet and Detoxification, Laetrile, Vitamin C and Macrobiotics, and Immuno Therapy" are described in detail. Comments on orthodox therapy such as surgery, radiation and chemotherapy are brief and seem to be viewed as expressions of limited and primitive medical philosophy.

Glassman provides a synopsis of those qualities she believes denotes a cancer survivor such as the will to live, the joy in wanting to be alive and a positive belief in recovery. Empahsis is on taking charge or action in responsibility for one's own life. The type of treatment becomes of secondary importance so long as these attitudes and attributes are present.

The cancer patient reading this book and undergoing orthodox therapy might well view their treatment as negative. Further, they might be also led to believe that if the treatment becomes unsuccessful they themselves are responsible and should feel guilty for not becoming a survivor. Thus it seems that the overall theme presented of how to become a cancer survivor is deceptive and could be misinterpreted by cancer patients and their families as well as health care professionals. We do not recommend this book.

Ward D. Noyes, M.D.
and Karen Keroack
Gainesville

● Dr. Noyes is Professor of Medicine and Chief of the Division of Hematology and Ms. Keroack is a Social Worker in the Department of Hematology/Oncology at the University of Florida College of Medicine, Gainesville.

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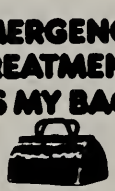
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Auxiliary Liaison Editor — **Mrs. Walter (Isabella) Laude**

An invitation — the Auxiliary needs you

As state membership chairman for the Auxiliary, I would like to invite every physician's spouse to join the Auxiliary. We need YOU. If you are not a member, please join us, and together we can do more.

The Florida Medical Association Auxiliary is one of the finest volunteer groups in the world. I am proud to say that I am an active member. I find the Auxiliary rewarding and worthwhile. This year again promises to be challenging. We have the second largest membership in the nation. Our goal is to become number one. Please join with me as we tackle areas of concern ranging from child abuse, violence on television, the aging, health careers, drug abuse, scholarships, public relations, legislation, and with special programs such as Meals-on-Wheels and Buckle-up-Baby.

Our membership is divided into various categories to meet the needs of each individual: the male spouse, new member, international spouse, widow, member-at-large, and career spouse.

We need you and want you to have an organization where you feel as an individual. We place great value on each individual member who is vital to our organization. You do not have to be a chairman or hold an office in order to express your thoughts. Your voice can be heard. Ideas can become worthwhile projects. We dare to be different!

If we see a health problem in our community that needs our attention we form a committee, plan what needs to be done, and go forth with dedication to solve the situation. I challenge any doctor and their spouse to come to a meeting, hear about our projects, and not go away feeling overwhelmed and in awe of all the many accomplishments.

I also see a need for support groups among medical families to help with these stressful times. I am asking every county to form such groups this year. We need to let our members know we are willing to help each other in times of sickness, family troubles, law suits, or anytime a friend is needed. Friendship is one of the most valuable treasures we can receive. Through my involvement in the Auxiliary I have gained many friends, and thank the Auxiliary for this opportunity.

We must take the time this year to meet together as a medical family, relax in informal surroundings, and get to know each other better. A few suggestions would be a family picnic, pot-luck supper, cook-out, or anything you can think of that is not expensive with the workload being shared by all. Let's have some fun, and form new friendships.

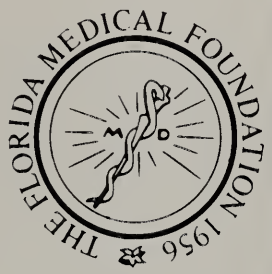
Your help is needed. Become part of a network of physicians' spouses united by a common bond for a common goal — to improve the health and quality of life for all people. There is no greater satisfaction than knowing that your volunteer efforts have helped your fellowman.

We are always open to creative thinking and good ideas, so let me hear from YOU. Join today. Write to me...Susan Marks,,374 Golfview Road, North Palm Beach, FL 33408.

Mrs. V. A. (Susan) Marks
First Vice President, FMA-A
North Palm Beach

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. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104 672-681, September 1982
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302 1269-1273, June 5, 1980

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates. PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis. Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request

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PRESIDENT'S PAGE

Progress Report on PLI



I began my term as President of the FMA on May 6 without any knowledge of the fact that within 48 hours the State Insurance Commissioner of Florida armed with a court order would give the Florida Physicians' Insurance Reciprocal (FPIR) 30 days in which to show cause why it should not be placed into receivership. The Department's action was based on the results of a triennial examination of the FPIR that raised grave concerns that the FPIR had a serious deficiency in its surplus and was in jeopardy of not being able to discharge its liabilities. This action by the Department shocked the leadership of the FMA and those physicians who receive their professional liability protection through the FPIR.

Your Board of Governors acted immediately to investigate the problems of the Reciprocal and began a strenuous effort to seek a solution that would assure physicians covered by FPIR continuity of professional liability protection with no lapse in coverage. In the 2½ months since the Department's action, your Board has devoted untold hours and effort exploring every possible viable solution to this dilemma. I have also attempted to keep you informed on a timely basis regarding the status of the Reciprocal and the progress of our efforts in your behalf. I am pleased to report that we are now actively working to develop what I am optimistic will prove to be a successful and lasting rehabilitation plan for the FPIR as well as identification of alternative sources of professional liability protection including prior acts coverage with no interruption in coverage.

You will recall that in my President's Memo of July 20, I advised you that on July 19 we were invited to meet with representatives of the Florida Department of Insurance to discuss the status of the Reciprocal and the proposed development of a plan for rehabilitation of the company to which the Department is committed if at all possible. In order to be successful, the rehabilitation plan will require a contribution of capital by subscribers of FPIR along with a total restructuring of the company, including new management. As a result of the meeting held throughout the state last week by the Department of Insurance with physician subscribers of the Reciprocal, 2,400 out of 2,800 physicians responded to the Department's survey and indicated that they will participate in a rehabilitation plan.

An important element of the proposed rehabilitation plan is the reestablishment of negotiations by the Department with Physicians Insurance Company of Ohio (PICO). These negotiations have been carried out with the full support and participation of the FMA.

I am pleased to report to you that as a result of a meeting on August 14 between representatives of the FMA, PICO, and Insurance Commissioner Bill Gunter and members of his staff, an agreement was reached in principle that in the best interest of the physician subscribers of FPIR that all parties will work toward the development and implementation of a rehabilitation plan for the Reciprocal, rather than liquidation. Under this plan, PICO will assume total management of the company subject to substantial participation by the current subscribers of FPIR and approval of the plan by the Receivership Court. Within the next few days, physician subscribers will be receiving a detailed memorandum from the Insurance Department regarding the plan and the amount of contribution to capital required. Your contribution will be as follows:

Classification 0-1-2	$2,000
Classification 3-4	$5,000
Classification 5-6-7	$8,000

Payment of half of the contribution to capital will be due by October 1 with the balance due by December 31, 1984.

It is anticipated that there will be an increase in premium effective January 1, 1985. The increase, while not determined at this time, will be at a level competitive with anticipated increases by other carriers in Florida.

You will also be receiving information directly from PICO regarding the restructuring and future management of the company and the opportunity for conversion of the Reciprocal to a stock company at the earliest possible date in 1985.

As I advised you in my earlier communications, the FMA feels that the PICO proposal offers a highly satisfactory solution to the problems of the Reciprocal. I will keep you advised of ongoing progress of the cooperative effort by the FMA, PICO, and the Insurance Department to successfully finalize and implement a rehabilitation plan. The success of this plan will result in the Insurance Department petitioning the Court to lift the rehabilitation order and allow this reorganized and newly managed physician-owned company to continue to provide professional liability protection for Florida physicians. The FMA recommends that all physician subscribers to FPIR seriously consider participating in the rehabilitation plan under the management of PICO.

You will recall that I also advised you in my July 20 memo that the FMA Board of Governors had endorsed the offer extended by Physicians Protective Trust Fund (PPTF) of Coral Gables to provide uninterrupted PLI protection, including prior acts coverage for those physicians currently insured by FPIR who may wish to apply subject to approval by PPTF's reinsurers and the appropriate regulatory agency. I would like to report to you the status of this proposal for your consideration.

PPTF is offering PLI coverage to physicians presently insured with FPIR, including prior acts coverage with no lapse in coverage subject to the necessary underwriting procedures. Effective August 1, 1984, each such insured is required to make a contribution to the fund balance (surplus) of PPTF in the amount of $2,000 and with each such contribution being evidenced by a surplus note issued to the insured by PPTF, such contribution to be returned to the insured at such time and such amounts as the Board of Trustees of PPTF may deem feasible. This subordinate loan is sought by PPTF to maintain the strength of its financial buffer against adverse experience, as PPTF increases its membership. As the need for the buffer decreases by accumulation of surplus, the loan will be repaid to the insureds. You will also be receiving information directly from PPTF regarding their proposal.

Based on the developments outlined in this report, your Board of Governors is optimistic that we have achieved our goal of developing a viable mechanism whereby every physician currently insured by the FPIR will be assured continuity of PLI protection with no interruption of coverage and which offers the best possible assurance of long-term stability. It is important to note that James H. Sammons, M.D., Executive Vice President of the American Medical Association and I met with Governor Bob Graham on August 8 to discuss the seriousness of professional liability insurance in Florida and throughout the entire nation. The Governor expressed his concern for the magnitude of the problem and offered his support and encouragement for finding a resolution to the problem, including the current cooperative efforts to rehabilitate the FPIR.

We recognize that time is of the essence, and we will keep you advised as we work toward finalizing the resolution to this difficult problem.

Frank C. Coleman MD

EDITORIAL

W. Harold Parham, D.H.A.

I became a member of the FMA in 1948. Harold came with the FMA in 1949. I first saw him in either 1949 or 1950. Here was this fine young man with the venerable and much loved Dr. Ed Jelks. He was tenderly and almost lovingly looking out for Dr. Jelks' every need. These two represented FMA at the legislative sessions. They were the FMA representatives and for some years Harold was the representative alone.

James B. Herrick, M.D., a great physician born 100 years ago, put it well, "the physician should have a dual personality, scientific toward disease but humane toward the patient." This applies to Harold. He is scientifically and devastatingly factual, knowledgeable and effective toward a problem or adversary but very humane and solicitous toward his doctors, their spouses and families.

When does a person like Harold retire, a man who is so good at everything and so valuable to an organization of physicians and to the many people who have depended upon him? A man seemingly indefatigable, always ready, sharp and in control of facts, figures and bringing things out like a computer. Certainly not dull, nor a drudge, nor a drone. A workaholic, yet there and ready when fun, relaxation and lighter things begin. The smart person knows when to slow down or shift interests. It may be intuitive. Better not wait for tell-tale, subtle, insidious signs or too long, too late and be eased out. Harold is relinquishing his FMA responsibilities at the height of his capacities, abilities and accomplishments. That says a great deal about the man. He wisely does not feel that he is indispensable. He is willing to pass the mantle to others, younger, very capable, whom he has guided along according to his exacting demands. He is concentrating now upon what he feels is a most crucial and important problem — that of professional liability, tort reform and helping his doctors in these areas. How fortunate for us. This is the mark of a man who puts his dedication to his work and his organization first and his own self and welfare second. He subverts ego and need for respite for the success and perpetuation of the principles and objectives for which he has striven for so many years. He is doing this in spite of the strains on his body and mind. Like his doctors, he has missed out on a normal family life. Our wives and families suffer, but our organizations and patients are the beneficiaries of our energies, knowledge, abilities and dedication. In this sort of context, Harold Parham exemplifies the beloved physician.

Harold is just changing gears and lanes. His motor is running smoothly. His cerebral synapses are carbon free. Harold, you have a passion and capability to perform well. Now adjust, relax and feel that you do not have to compete. As a senior, albeit a young senior, you can have the luxury of not having to be so painfully sensitive to others opinions and judgments. No longer must you constantly deliver virtuoso performances. Enjoy your wife and family more. It may go against your grain, but try not to put off those nice things that we always put off "for later."

Relinquishing your FMA position and all it has meant may be hard, sad, depressing. But look around, smell the roses, walk the leisurely primrose path. Make life more like vintage wine to be enjoyed slowly, and do not expect to fill the new cup always to the top.

When I was in medical school in Baltimore, I went to a play in which Walter Huston had the leading role. He was the father of John Huston, the movie producer. In this play, Walter Huston sang a

song which has very appropriate words for tonight. The words went like this: "When I was a young man courting the girls, I played me a waiting game. I just let the old earth take a couple of whirls, and as time came around they came my way. As time came along they came. It's a long, long time from May to December and the days grow short when you reach September. And the autumn weather turns the leaves to flame and I haven't got time for the waiting game. The days dwindle down to a precious few — September, November. And these few precious days I'll spend with you. These golden days I'll spend with you." Harold and Mary, you have many golden days to spend together.

When you are proud of your life's accomplishments, and you should be because your accomplishments are there for all of us to see — let us go back ten years to a most extraordinary event that took place during the 100th anniversary meeting of the FMA at Hollywood ten years ago this month. At this time, all of Harold's accomplishments were enumerated for all of us to see and hear. This event was extraordinary because it was the first time that an academic convocation of the University of Florida was ever held off campus. The University of Florida bestowed upon Harold the honorary degree of "Doctor of Health Administration" and they felt that this should be done before all of us whom Harold had served so devotedly and magnificently for at that time 25 years, now 35 years, so they brougth the convocation to our meeting. How fitting. What an honor to Harold and Mary. The Vice President for Health Affairs of the University of Florida, Dr. Ed Ackel, the Dean of the Medical School, Dr. Chandler Stetson, and the Deans of the University of Miami and of the University of South Florida Medical Schools, Drs. Manny Papper and Don Smith, were present in full academic regalia. What an occasion. We were all so proud and it was so fitting. Harold received his honorary degree, D.H.A. Mary also has her degree, D.H.A., Doctor of Harold Administration. All of these wonderful proceedings are set forth in JFMA of July 1974, Vol. 61, No. 7, pages 515-516.

When you are respected by your peers, and Mary and Harold certainly are; when you have a stable and rich family life and the same spouse you started with; when not one of your children turns out to be an ass or a dolt; when you have good health and you, Mary and Harold, have all of these, then having all of these as you both do makes the prognosis for a rich change of direction or retirement very good. You have all of this Mary and Harold, and we are so proud of you.

As I grow older, I have the strong feeling and desire to tell my friends and those I respect, admire and love just how I feel about them and to tell them in person before it is too late. I want to truly and sincerely say for both Marie Palmer and me (and I wish that she could be here with us tonight) we love you Mary and Harold. We are so glad to be your friends. We wish all the best for you and your family. We wish you both continued satisfaction in your lives and good health. May God bless and keep you both.

I am sure that all of these wonderful people, your friends who are gathered here tonight in your honor, feel the same way as Marie and I do. We are all here in a common bond of affection and love for you two extraordinary people. God love you all and thank you, President Lee Dockery, for allowing me the honor and privilege of saying what is in my heart.

George S. Palmer, M.D.
Tallahassee

NOTE: Some of the ideas expressed here were "borrowed" from an article under *Commentary* in JAMA, August 12, 1983, Vol. 250, No. 6 entitled, "When Does a Surgeon Retire?" by Irving A. Bunkin, M.D., Santa Fe, NM.)

Presented on the evening of May 2, 1984 at the Contemporary Hotel, Lake Buena Vista, Florida.

The *essentials* of accreditation

In this era of accountability, the medical profession is finding itself under greater scrutiny and as a result, the traditional roles of undergraduate, graduate, and continuing medical education cannot escape examination. Since formal preparation for medical practice is viewed as a continuum, the rapid explosion of new technology increases the importance and value of the third educational phase.

Although the debate lingers concerning mandatory versus voluntary continuing medical education, and problems are evident in measuring the impact of these activities on physician behavior and competence, few practitioners proceed through their professional careers without actively seeking additional formal training.

Since participation in continuing medical education requires an investment of time and frequently money, the prospective participant should demand and rightly deserves some assurance that the educational endeavor will be worthwhile. This assurance is central to the process of accreditation.

Including the Florida Medical Foundation Committee on Continuing Medical Education, there are currently 27 hospitals and associations in Florida

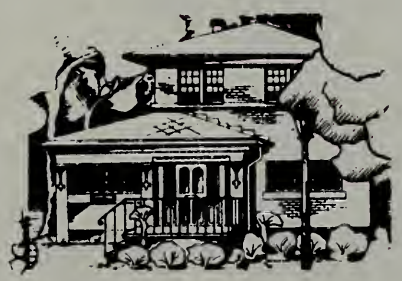
accredited by the Accreditation Council on Continuing Medical Education (ACCME). Such accreditation allows these organizations to certify that certain continuing medical education activities which they sponsor or co-sponsor meet the criteria for American Medical Association Category I credit. In order to gain the status of ACCME accreditation, various processes and requirements must be met. Any educational entity desiring accreditation must present evidence that it is meeting the standard criteria of seven *Essentials* described as follows:

- The sponsor shall have a written statement of its continuing medical education mission, formally approved by its governing body.
- The sponsor shall have established procedures for identifying and analyzing continuing medical education needs and interests of prospective participants.
- The sponsor shall have explicit objectives for each CME activity.
- The sponsor shall design and implement educational activities consistent in content and method with the stated objectives.
- The sponsor shall evaluate the effectiveness of its overall continuing medical education program and component activities and use this information in its CME planning.
- The sponsor shall provide evidence that management procedures and other necessary resources are available and effectively used to fulfill its continuing medical education mission.
- The sponsor shall accept responsibility that the essentials are met by educational activities which it jointly sponsors with non-accredited entities.

Organizations or institutions seeking accreditation should initially conduct a self-assessment based on their ability to comply with each *Essential*. If substantial compliance is indicated, an application may be submitted to the Florida Medical Association Committee on Medical Education along with the required application fee. If the application is complete and viable, an on-site visit will be scheduled which typically includes three experienced physician educators and a member of the staff. During the visit, meetings are scheduled with individuals directly responsible for CME activities within the organization or institution and a recommendation is subsequently made to the Florida Medical Association Committee on Medical Education for final action. Should accreditation be granted, a provisional period of no more than two years is allowed. After the initial provisional period, an application for re-accreditation is required and either an on-site visit is scheduled or a "survey-in-reverse" is conducted with applicants in attendance at a meeting of the Committee on Medical Education. After the provisional period, subsequent periods of accreditation may be granted up to a maximum of six years. An application for re-accreditation is required at the end of each period of accreditation.

The process of accreditation demands a sincere, ongoing commitment by those hospitals and associations who have earned the privilege to certify AMA Category I credit. Accreditation serves as educational quality assurance and it allows the physician-learner an opportunity to be a more informed consumer in the continuing medical education marketplace.

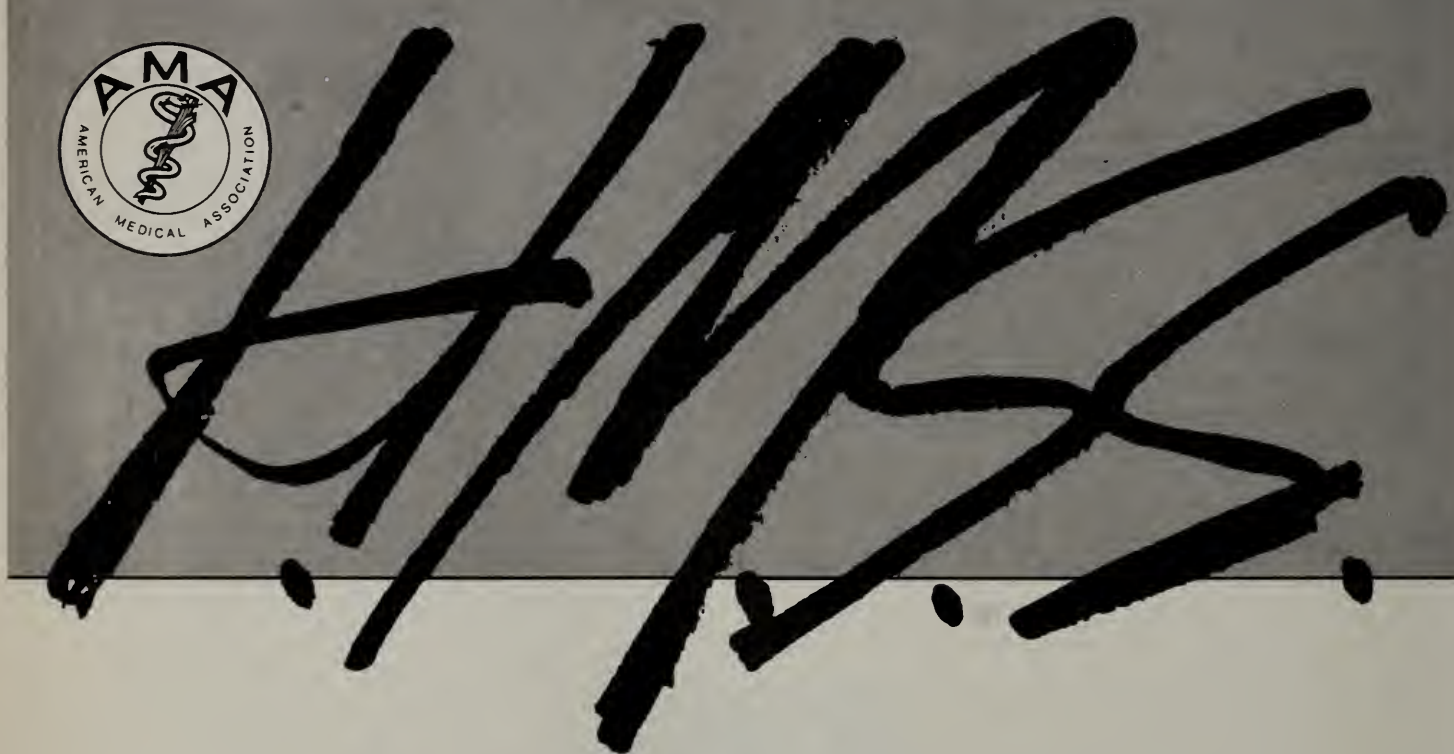
Robert C. Fore, Ed.D.
Executive Editor



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One Hundred Tenth Annual Meeting Florida Medical Association, Inc. Lake Buena Vista, May 2-6, 1984

President's Address
J. Lee Dockery, M.D.

Mr. Speaker, fellow officers, delegates and distinguished guests, it seems such a short time ago that I stood before you and we pledged to work together in the year ahead. I have thought of that day, May 8, 1983, many times as I have crossed through difficult problems when it seemed almost impossible to succeed. No person does a job alone. It is impossible. There is a cast of thousands in the wings — some of whom you know, and some of whom you do not know — they are there to help and guide you. It is appropriate that I give thanks to some of these people this afternoon, and I hope you will indulge me while I do so.

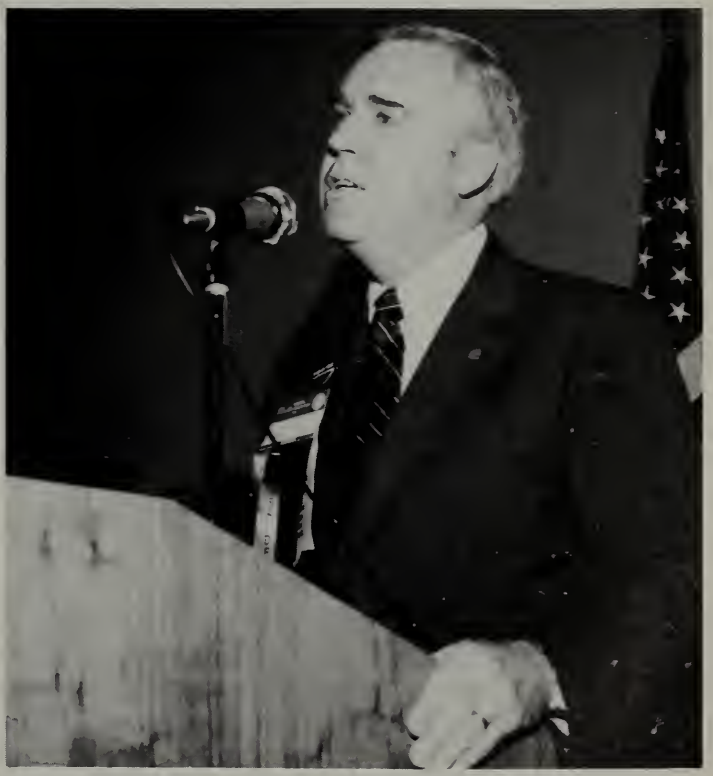
The first group that needs to be thanked, of course, is my wife and my family, without whose support I could not have made this year what it has been.

It is important that I give thanks to the people who made my being President possible and that is the delegates and members of the Alachua County Society who have supported me for this important position — along with those people, of course, who are members of the Gator Group, which have been very helpful and supportive.

I also in real life have a real job, and it is appropriate that I pay tribute to the University of Florida College of Medicine, and my friend and colleague, Dr. William B. Deal, who has given me the opportunity to give this time to the Florida Medical Association. The secretarial staff has handled the voluminous amount of work without complaint and with total desire toward doing their best job in the most expedient way possible.

The officers, the Board of Governors, the councils and the committees of the Florida Medical Association have worked tirelessly to combat the many forces affecting the practice of medicine to preserve access to quality health care for all patients. Over 435 members of the Florida Medical Association have worked through the various councils and committees serving you and the Florida Medical Association this past year.

The staff members of the Florida Medical Association worked diligently to serve the members of the Association, and I would like to pause and thank them for their untiring effort. Never once have I asked for anything to be done on behalf of the



J. Lee Dockery, M.D., FMA President

membership that it has not been performed willingly and promptly. It has been a unique honor for me to have the privilege to also be President during Dr. Harold Parham's final year of 35 years of devoted service to this outstanding organization. Dr. Parham, we pay tribute to you for all that you have done for the Florida Medical Association. To Mr. Donald Jones, I am most grateful for the tremendous help he has been to me throughout this year. He has been my companion on many late flights to the county medical society meetings when weather conditions have not always been the best. Mr. Jones does not know the meaning of "I can't" or "I don't know." The Florida Medical Association will be in very capable hands under Mr. Jones' leadership.

The Florida Medical Association Auxiliary is the best representative of organized medicine we have. I have been extremely fortunate to have had the opportunity to work with Mrs. S. Bruce Gerber, affectionately known as Priscilla, as President of the Auxiliary. Mrs. Gerber is a very capable and pleasant leader. Under her leadership, we and the Auxiliary have accomplished a great deal this year. The Alachua County Chapter of the Auxiliary, through its President, Mary Lou Hawkins, has also been totally supportive and very helpful throughout the year. The Auxiliary also will be well served in the name of Nancy Smith who will take the helm after Priscilla.

And to you the delegates and the members of the Florida Medical Association I pay tremendous tribute. You have become active and through your respective component societies you have stimulated members to get involved. You have honored me in a way that few are honored. You have permitted me to represent you in the arena of organized medicine locally, regionally and nationally. Many county societies have invited me to visit and have treated me with courtesy and affection, and I am grateful for your tremendous support and friendship, but I am not elated and prideful of all of the achievements that we were not able to accomplish this past year. We have not yet begun to end the health care revolution. We have not yet succeeded in informing our members that we are in a revolution and what the revolution is all about. The forces at work are an epidemic of assault on medicine with many of the same surprise and disbelief among physicians as December 7, 1941 was to the United States when Japan bombed Pearl Harbor.

Medicine and the public • We ourselves continue to be intoxicated with our aura of respect and power as physicians, and we are not hearing the discontent of the public as they need and use our services. The public is confused with the various competitive initiatives presented to them as other interest groups become salesmen and vendors of health care. And the public is saying they cannot afford to be ill any longer. Industry and employers are saying, "We are going broke," because they cannot afford the health care benefits for their employees. Everyone is looking to the physicians for answers; "medicine" write us a prescription! And we are surprised, threatened, defensive and not responsive in a convincing way to the public.

Because we are disorganized and have not — and do not — keep up with the changing forces, we become less capable of responding and become more isolated in maintaining control and influencing the outcome of the revolution that is not fought with handguns and cannons but with the more powerful weapons of distorted truth, loss of ethics and competition of unqualified people who want to be thought of as physicians who can give better care cheaper.

Medicine is the largest industry in Florida — in the nation — and everyone will need or use our services at some time. But, if medicine were an ordinary industry and the consumer was unhappy with our product, we would be forced to examine our manufacturing or marketing techniques, and we would make appropriate corrections and responses to improve any deficiencies. Why are we not applying the same principles to medicine? Because of medicine's delay in response, we have permitted others to tell us what is best for us. To legislate and to regulate reforms which are not solutions, but give the image to the public that something is being done, even if the solution changes options for the patient and the physician.

The patients and the public are getting incorrect answers because we are not telling the story that needs to be told. The public has unbelievable expectations because of fantastic discoveries in medicine which have prolonged and increased the quality of life. We, as a profession, have not promoted wellness, but have oriented ourselves to the treatment of disease. We have resorted to ordering the most advanced tests or procedures to rule out the terrible disease rather than the tried and true physical examination and communication with the patient in a concerned way, which creates compliance and confidence rather than ordering the $24,000 in tests to rule out the brain tumor in the patient with a headache and a negative neurological exam. The public and the third-party payers see physicians as controlling the ink that orders the tests, admits the patients, determines the length of stay in acute care hospitals, and ultimately writes the bill for both the hospital and physician care.

Health care costs • In 1982, there were $322.4 billion dollars spent on personal care in the United States. Was this a bargain? Yes. Life expectancy has increased from 68.2 years in 1950 to 74.5 years in 1982. Infant mortality continues to drop from 29.2

per thousand births in 1950 to 11.2 per thousand births in 1982. Of the $285.9 billion dollars which provided personal care at the amount of $1,215 per citizen in the United States spent on every American for health care, which paid for 4.5 to 5 visits per year to the physician, and we are talking about now, 2 to 2½ visits per month for every American. For the over-65, 6.3 visits per year or less than once every two months. When you look at the number of people in this country who are under-served, you can see how the utilization increases for those who are utilizing the services. We have the best health care system in the world in which we have free choice of where the care is given and by whom. Qualified personal care is available 24 hours a day, seven days a week, 365 days a year. But the public, in a poll in 1983, is saying the costs are too high regardless of the facts. Sixty-five percent of the American people feel that their health care is costing too much. Perhaps just as significant is the fact that only 55% of the people are very satisfied with their care. Another 34% say that they are fairly satisfied. There are now in excess of 500,000 physicians in this country, of whom over 400,000 are in active patient care, with over 375,000 in non-federal private, personal care in our offices throughout this country. There are 15,700 new M.D.s graduating from the 127 medical schools per year. With a captive audience of one to one, how can we reach the point that only 55% of our customers are very satisfied with our product, and only 57% are very satisfied with the way they are treated by the doctor's staff? Our public, our patients, are there for us to serve every day and to please every day. Could Coca-Cola and other industries survive on 55% complete satisfaction? What can be done?

I just attended the Committee on Allied Health Education and Accreditation meeting in Chicago, April 23-26. There are over 3,000 accredited allied health programs in this country located in 1800 institutions, graduating nearly 38,000 people in 25 allied health fields, many of whom want to practice medicine and have hospital privileges and charge for those services. In every session of Congress, the American Medical Association reviews approximately 1,000 bills pertaining to medicine and health. Last year in the Florida Legislature, over 242 bills were introduced dealing with health and medicine. In this legislative session, right here in Florida, we will surely end up with some form of regulated cost containment of health care.

Looking ahead • An issue such as licensure of lay midwives, schools for lay midwives, pharmacist's health care consultants, physical therapy licensure, respiratory therapy licensure, hospital staff privileges for non-physicians are but a few of the competitive efforts to intrude, yes intrude, on medicine by non-physicians, and of course, the continued lack of response and resolutions of medical malpractice problems by the legislature continues to escalate our frustration and disappointment. But we must not be depressed; we must not be disorganized, and we must not combat these issues with anger. It is not too late to get the House of Medicine in better order. We must establish and reestablish in every county medical society new member requirements in which new members will be instructed and tutored concerning the requirements of ethical and professional considerations and responsibilities in their practice of medicine. We can establish services to the underserved and the needy in our respective communities. We can ferret out those among us who gouge the public and over-utilize and over-prescribe. We can identify those of us who are impaired and need help before the public identifies us and paints us in medicine with the broad brush of their image. We can communicate with the public. We can tell our story of the real costs of medical care; the problems of medical malpractice. We can talk to our patients; we can touch our patients. We can reduce costs by the orders that we write, and more importantly, the orders that we do not write. We can return to caring rather than transferring the role to others who do not have the skills and the knowledge to do it as well. We can each pledge ourselves to leave our halo and mantle of doctoring and lend our energy and talent and intellect to some community project. We are the most capable, we are the most intelligent, we are among the most highly paid for our services, and yet few of us become involved in our community. We must give to our communities rather than take from our communities. Who can represent us better than ourselves? And we must become more organized and vibrant in our relationship with each other. We must communicate and become informed. We must work with unified force and speak with one voice.

I am pleased if the Reference Committee and you, the delegates, decide if a new Council on Hospital Medical Staffs will be established to improve communication and representation among the members of the Florida Medical Association. Also, if approved, the different recognized specialty societies will be represented in the House of Delegates by seated delegates and alternate delegates status representing each specialty society; but in the end, the outcome is the responsibility of each of us.

We collectively could be the biggest and best HMO, PPO or IPA, but we must want to do it before we can do it. We are making strides. Each of the leaders of the Physician Protective Trust and the Florida Physicians United have said they desire the voice of medicine to be the Florida Medical Association. I know they mean it, because they have shown it with their actions. We must keep up the momentum. Let us together mount the energy and the action to adjust the health care industry to the product appro-

priate for the public and ourselves at this critical time in our history. Access and quality care for everyone at an affordable cost.

Ladies and gentlemen, colleagues and friends, thank you for the honor that you afforded me and my family. We love you, and we will treasure these fond memories of our relationship as long as we live.

Thank you.

Governor sends greetings to FMA House of Delegates • The following message was received by President Dockery from Governor Bob Graham:

> Greetings:
>
> It is a pleasure to welcome you to the Annual Meeting of the Florida Medical Association in Lake Buena Vista.
>
> Lake Buena Vista is an excellent site for this meeting. While you are here, we hope you will have an opportunity to visit some of the many entertainment and cultural attractions for which this area of our State is famous.
>
> Your organization provides an invaluable service to members by keeping them informed of the latest changes and advances in the medical profession. The Florida Medical Association also contributes significantly to improving the lives and health of residents in communities throughout our State.
>
> I regret that I was unable to be with you this weekend, but look forward to hearing the outcome of your discussions.
>
> Best wishes for a pleasant stay in Florida.
>
> Sincerely,
>
> Bob Graham
> Governor

First House of Delegates

The First House of Delegates convened at 3:30 p.m. on Wednesday, May 2, 1984 in the Great Hall Center of the Buena Vista Palace Hotel, Lake Buena Vista, Florida, with James B. Perry, M.D., Speaker of the House, presiding.

The House rose for the invocation which was given by James T. Cook Jr., M.D., and remained standing for the pledge of allegiance.

Dr. Perry announced the membership of the Credentials Committee:

David R. Arrowsmith, M.D.
E. Joan Barice, M.D.
Dolores A. Morgan, M.D.

The Delegates were reminded that they must register with the Credentials Committee before this and every meeting of the House of Delegates.

Dr. Arrowsmith, Chairman of the Credentials Committee, announced that 198 Delegates were present, representing 37 component societies, which constitutes a quorum.

A motion carried to seat the Delegates.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; Charles P. Gibbs, M.D.; D. Orvin Jenkins, M.D.; Mr. James B. Dolan, Student Delegate; (Absent — Mark V. Barrow, M.D.; William B. Deal, M.D.; William T. Hawkins, M.D.)

BAY — James T. Cook III, M.D.; B. Philip Cotton, M.D.; (Absent — William G. Bruce, M.D.)

BREVARD — Raymond A. Armstrong, M.D.; Richard I. Barr, M.D.; James E. Carter, M.D.; Walter A. Cerrato, M.D.; Paul J. Popovich, M.D.; Robert C. Ufferman, M.D.; (Absent — Ovidio E. Vitas, M.D.)

BROWARD — Andre S. Capi, M.D.; Arthur L. Eberly, M.D.; Paul A. Flaten, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Ray E. Murphy Jr., M.D.; Ernest G. Sayfie, M.D.; Marvin L. Stein, M.D.; (Absent — Bruce B. Burgess, M.D.; Phillip A. Caruso, M.D.; Ernest Costantino, M.D.; David A. D'Alessandro, M.D.; Willis N. Dickens, M.D.; Kenneth H. Farrell, M.D.; Stanley S. Goodman, M.D.; Theodore W. Hahn, M.D.; John M. Harper, M.D.; William C. Hartley, M.D.; Wilbur F. Helmus, M.D.; James A. Jordan, M.D.; David C. Lane, M.D.; George P. Messenger, M.D.; Donald J. Plevy, M.D.; Joseph Sachs, M.D.; Richard D. Schultz, M.D.; H. Murray Todd, M.D.; Peter A. Tomasello, M.D.; Anthony J. Vento, M.D.; Juan S.A. Wester, M.D.)

CAPITAL — Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Robert N. Webster, M.D.

CHARLOTTE — Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; (Absent — Jaime Torner, M.D.)

CITRUS — Alexander E. Hlivko, M.D.; W. Randall Jenkins, M.D.

CLAY — Clarence M. Harris, M.D.; Hinson L. Stephens, M.D.

COLLIER — Charles J. Montgomery, M.D.; Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.

COLUMBIA — (Absent — Leela Swamy, M.D.)

DADE — Edward R. Annis, M.D.; Jerome Benson, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; Vincent P. Corso, M.D.; O. William Davenport, M.D.; Miguel Figueroa, M.D.; N. Ralph Frankel, M.D.; Alan S. Graubert, M.D.; Joseph Harris, M.D.; James J. Hutson, M.D.; Donald E. Johnson, M.D.; Norman M. Kenyon, M.D.; Maurice H. Laszlo, M.D.; Simon E. Markovich, M.D.; Dolores A. Morgan, M.D.; Sheldon D. Munach, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Arnold F. Schild, M.D.; Margaret C.S. Skinner, M.D.; Samuel P. Stokley, M.D.; Chauncey M. Stone, M.D.; Osvaldo D. Valdes, M.D.; Edgar W. Webb, M.D.; Harold H. Weiner, M.D.; (Absent — Jose S. Bocles, M.D.; Harlon S. Chiron, M.D.; Richard C. Clay, M.D.; Norman T. Ditchek, M.D.; Charles A. Dunn, M.D.; Richard J. Feinstein, M.D.; Richard L. Glatzer, M.D.; Julian H. Groff, M.D.; Sean M. Kaufman, M.D.; Jesse G. Keshin, M.D.; Jose F. Landa-Gutierrez, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Morton L. Miller, M.D.; William T. Mixon, M.D.; Charles A. Monnin Jr., M.D.; Miguel A. Mora, M.D.; Jose R. Pujols Bosch, M.D.; Pedro A. Ramos, M.D.; Oscar Sandoval, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; George A. Simpson, M.D.; Douglas Slavin, M.D.; Marvin B. Slotkin, M.D.; Charles F. Tate, M.D.; Steven M. Weissberg, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; Ms. Ana Isabel Gonzalez, Student Delegate)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Samuel J. Alford Jr., M.D.; Harvey E. Bernhardt, M.D.; Clyde M. Collins, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Walter A. Harmon, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; Kevin M. McAuliffe, M.D.; Charles B. McIntosh, M.D.; Daniel B. Nunn, M.D.; Guy T. Selander, M.D.; Robert H. Threlkel, M.D.; James W. Walker, M.D.; William D. Walklett, M.D.; (Absent — Gaston J. Acosta-Rua, M.D.; William J. Garoni Jr., M.D.; John F. Lovejoy Jr., M.D.; Faris S. Monsour, M.D.; John A. Rush, M.D.)

ESCAMBIA — Richard H. Ciordia, M.D.; Charles J. Kahn, M.D.; Theodore J. Marshall, M.D.; Charles F. McConnell, M.D.; Michael R. Redmond, M.D.; Robert K. Wilson Jr., M.D.; Henry M. Yonge, M.D.

FLAGLER — John M. Canakaris, M.D.

FRANKLIN-GULF — Joseph P. Hendrix, M.D.

HERNANDO — Clinton J. McGrew Jr., M.D.

HIGHLANDS — (Absent — Carlos J. Gonzalez, M.D.; Luis M. Pena, M.D.)

HILLSBOROUGH — Richard A. Bagby, M.D.; Frank C. Coleman, M.D.; Richard G. Connar, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Richard S. Hodes, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Benedict S. Maniscalco, M.D.; Robert E. McCammon, M.D.; Ralph E. Rydell, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D.; Mr. Roland Reeves, Student Delegate; (Absent — Thomas E. McKell, M.D.; Ronald L. Seeley, M.D.; Harold L. Williamson, M.D.)

INDIAN RIVER — Donald L. Ames, M.D.; Randall D. Bertolette, M.D.; Paul W. Taylor, M.D.

LAKE — Joseph A. Comfort, M.D.; Joseph E. Holland, M.D.; Robert H. Hux, M.D.

LEE — Larry P. Garrett, M.D.; Francis L. Howington, M.D.; H. Quillian Jones Jr., M.D.; Joseph P. O'Bryan, M.D.; Stephen R. Zellner, M.D.; (Absent — Cecil C. Beehler, M.D.)

MADISON — (Absent — Michael O. Stick, M.D.)

MANATEE — Thomas R. Busard, M.D; Julian Giraldo, M.D. Roger A. Meyer, M.D.; (Absent — William A. Boyce, M.D.; James T. Rogers Jr., M.D.)

MARION — James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.; (Absent — Claude B. Henderson, M.D.)

MARTIN — Fred S. Carter, M.D.; (Absent — Andrew F. Greene, M.D.; George E. McLain, M.D.

MONROE — (Absent — Ronald H. Chase, M.D.)

NASSAU — (Absent — Jose L. Castillo, M.D.)

OKALOOSA — David R. Arrowsmith, M.D.; Samuel M. Atkinson, Jr.,M.D.

ORANGE — Edward Ackerman, M.D.; Richard J. Bagby, M.D.; Manuel J. Coto, M.D.; Clarence M. Gilbert, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Calvin R. Peters, M.D.; Wallace M. Philips, M.D.; Charles T. Priee, M.D.; James E. Richards Jr., M.D.; Robert N. Serros, M.D.; Ceeil B. Wilson, M.D.; (Absent — Clifford D. Bidwell, M.D.; William E. Hoffmeister, M.D.; David L. Mackey, M.D.)

OSCEOLA — Gilberto Perez, M.D.; (Absent — Robert E. McMillen, M.D.)

PALM BEACH — Vernon B. Astler, M.D.; J.A. Baker, M.D. Elizabeth J. Barice, M.D.; Robert Burger, M.D.; Richard C. Cavanagh, M.D.; McKinley Cheshire, M.D.; Lee A. Fischer, M.D.; James R. Forlaw, M.D.; James M. Johnson, M.D.; V.A. Marks, M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D.; H. Peter Wintrich, M.D.; (Absent — John D. Corbitt Jr., M.D.; Ralph R. Eastridge, M.D.; William J. Romanos Jr., M.D.; James F. Smith, M.D.)

PANHANDLE — Herbert E. Brooks, M.D.

PASCO — Robert May, M.D.; Ross G. Olson, M.D.; Herman R. Reno, M.D.

PINELLAS — William W. Atkinson, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris J. LeVine, M.D.; Jack A. MaCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Howard L. Reese, M.D.; William H. Schmid, M.D.; Bruce P. Smith, M.D.; (Absent — Thomas M. Daniel, M.D.; Jose Galvez, M.D.; John M. Hamilton, M.D.; Walter H. Winchester, M.D.)

POLK — Ronald W. Case, M.D.; Thomas M. Caswall, M.D.; Saul B. Gerber, M.D.; John W. Glotfelty, M.D.; Wiley E. Koon, M.D.; John C. Moore, M.D.; Robert B. Peddy, M.D.; David Stoler, M.D.

PUTNAM — (Absent — Edward D. Risch, M.D.)

ST. LUCIE-OKEECHOBEE — Khalil A. Cassimally, M.D.; David L. Fromang, M.D.; Manuel G. Garcia, M.D.

SANTA ROSA — David B. Young, M.D.

SARASOTA — John N. Carlson, M.D.; Samuel E. Kaplan, M.D.; Kenneth C. Kiehl, M.D.; Douglas R. Murphy, M.D.; Franklin H. Pfeiffenberger, M.D.; Richard C. Rehmeyer, M.D.; Karl R. Rolls, M.D.; David L. Thomas, M.D.

SEMINOLE — Luis M. Perez, M.D.; Maria P. Perez, M.D.; (Absent — Maritsa C. Pastis, M.D.)

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Philip L. Carey, M.D.)

TAYLOR — John H. Parker, M.D.

VOLUSIA — Martin S. Feigenbaum, M.D.; Robert W. Lankford, M.D.; Roger K. Lewis, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Charles A. Stump, M.D.

WALTON — (Absent — Howard F. Currie, M.D.)

WASHINGTON — (Absent — Muhammad Amin, M.D.)

SPEAKER OF HOUSE — James B. Perry, M.D.

VICE SPEAKER — Franklin B. McKechnie, M.D.

A motion carried to adopt the Rules and Order of Business as listed in the Handbook, including a waiver of FMA Bylaws to allow nominations to be held Saturday afternoon, May 5, with elections on Sunday, May 6.

Information for Delegates

The Rules and Order of Business for the House of Delegates are included in this Handbook.

Delegates and alternates whose names appear in this Handbook have been certified by their county medical societies. Our Bylaws do not permit an alternate to serve for a delegate who has once been seated. **The Bylaws require that delegates fill out attendance cards at each meeting of the House of Delegates in order to be credited in attendance**, and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Your attention is called to the format of the Annual Meeting, where the Reference Committee meetings will be held in the morning following the First Meeting of the House. All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates. Members may request the Reference Committee chairmen to defer items in which they are interested in order that they may be present to discuss the subject.

All resolutions **must have a sponsor present before the Reference Committee.** Resolutions must be filed by 12:00 noon on the day of the First Meeting of the House of Delegates, typewritten and in proper form. The resolutions so presented will be available for distribution by the time the First House convenes. Only the "Resolved" portion of the resolutions will be adopted as policy.



Speaker of the House James B. Perry, M.D., Ft. Lauderdale, formally opens the first session of the House of Delegates. From left to right: Luis M. Perez, M.D., Secretary, Sanford; W. Harold Parham, D.H.A., Executive Vice President, Jacksonville; J. Lee Dockery, M.D., President, Gainesville; Dr. Perry; Franklin B. McKechnie, M.D., Vice Speaker, Winter Park; Frank C. Coleman, M.D., President-Elect, Tampa; James G. White, M.D., Vice-President, Ormond Beach; Yank D. Coble Jr., M.D., Treasurer, Jacksonville; and Robert E. Windom, M.D., Immediate Past President, Sarasota.

All Reference Committee reports will be duplicated and available to the delegates at the Registration Desk on Saturday morning. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook, (as well as the reports of the Reference Committees) have been printed on colored paper for easy reference. This color code is as follows:

Reference Committee No. I — Green
Reference Committee No. II — Buff
Reference Committee No. III — Blue
Reference Committee No. IV — Pink
Reference Committee No. V — Goldenrod

According to our Bylaws, nominations and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

The Speaker announced that a correction had been made to the Minutes of the 1983 House of Delegates as published in *The Journal of the Florida Medical Association, Inc.* to reflect that "Resolution 83-11, the Committee on Relative Value Studies, Lee County Medical Society" **was** adopted.

A motion carried to adopt the Minutes of the 1983 House of Delegates as published in the July 1983 issue of *The Journal of the Florida Medical Association, Inc.*, as corrected.

The Speaker introduced the officers of the Association: Franklin B. McKechnie, M.D., Vice Speaker; J. Lee Dockery, M.D., President; Frank C. Coleman, M.D., President-Elect; James G. White, M.D., Vice President; Luis M. Perez, M.D., Secretary; Yank D. Coble Jr., M.D., Treasurer; Robert E. Windom, M.D., Immediate Past President; W. Harold Parham, D.H.A., Executive Vice President.

Dr. Perry advised that during the past year a number of FMA members had departed this life. In memory of these physicians, roses had been placed in the vases at each end of the Speaker's podium. Dr. Perry asked that the House observe a moment of silent prayer in respect and memory of these members.

Remarks — Speaker of the House

In the last years we have seen medicine become the medium of alphabet soup — DRGs, HMOs, PPOs, PROs. This is not surprising but our membership slowly has become aware that medicine, for better or worse, will never be the same as it was five years ago, let alone one decade ago.

Our leadership has conjoled numerous legislators and individuals throughout the state in an effort to improve their understanding of our way of thinking. While the legislative leadership in this state has been helpful at times to the medical profession, on occasion, this has not been the case. These are elected officials, our representatives, as well as those of all of the people of Florida, and it would seem to the Speaker that there is always a way to solve a problem if the solution is searched for in a diligent manner. There are problems with cost containment, but tort reform goes hand-in-hand with this and we would urge an unbiased approach for a solution that will help all of the people of Florida, our patients, who incidentally will someday be each of us, as well as the lawmakers themselves.

In light of that, and reflecting upon your position as leaders in our state, I am hopeful that all of the physicians that you represent have aroused from their apathy of caring little for organized

medicine and are now interested in their own future and interested in communicating with you and supporting you in your understanding of medicine's problems in today's legislative and legalistic arena. Our business discussed here this week sets the course of Florida medicine for the next several months and our House of Delegates is the leadership that guides this Association in its policies, decisions, and yes, because we are human, its failures also.

As you know from previous years, but to reinterate briefly, our House of Delegates functions under the Rules of Order as published in Sturgis Code of Parliamentary Procedure. This will prevail unless otherwise provided for by the Florida Medical Association Charter or Bylaws, or unless waived or modified by a ⅔ vote of the members present of the House of Delegates.

The FMA Bylaws require Delegates to register by filling out cards at each meeting of the House. The Credentials Committee will attest to this and whether or not there is a quorum present. As a result, roll call will not be necessary.

The Reference Committees have been appointed and will meet to hear discussion and render a report compiled in their own executive session. Every member of the Florida Medical Association is invited to the hearings, to testify at them, and to participate in the discussions so that a consensus may be reached and decision, based on the majority of opinion, rendered and then submitted to this House. Authors or supporters of resolutions must be present to discuss their position and explain reasons for their proposal.

If an individual desires to discuss different issues in front of different Reference Committees and there is a time conflict, notification to the Chairman will suffice. He will take this into consideration and as a matter of courtesy, the problem will be handled expeditiously.

Council and Committee Chairmen are to be able to answer, enlighten, and encourage discussion over their area of expertise to members of the Reference Committee, as well as the membership. Each Reference Committee will have a senior staff person, a recording secretary, and an AMA delegate to monitor proceedings and assist in the discussions as necessary.

As in the past few years, to clarify double negatives it is suggested that if a Reference Committee disapproves of a recommendation or a report, it should recommend a vote of "NO" to the House.

Following the Reference Committees, their own executive sessions will be held and their reports completed. I have taken the liberty of appointing Dr. Thomas R. Busard and Dr. H. Quillian Jones to assist Reference Committee Chairmen in preparing their final drafts for presentation to the House. Reference Committee reports will be available for consideration by early Friday morning. This will usually be done in conjunction with the Speaker or Vice-Speaker. By early Saturday, the reports should be available to all delegations for consideration and caucus.

In an effort to expedite the meetings of the House, the Reference Committee will be encouraged to have a consent calendar. This portion will consist of items where there is no need for discussion. These statements will be listed as "approved, referred, filed, or disapproved." Any member of the House can extract any portion of any of the consent calendar for general discussion by making a motion to extract it and having a simple majority vote in the House. This will enable that portion of the extracted consent calendar to be opened for extended debate should it be necessary. The reason for the consent calendar is to allow more floor debate and consideration on the floor with meaningful discussion about events which are more important and pertinent to the Association. Obviously, the more mundane, but nevertheless important, issues which do not need discussion can then be passed over by a simple consent agreement of the entire House.

We know that every delegate has the opportunity and privilege of discussion of any issue that a Reference Committee brings before the House for consideration. We would encourage that this be done in Reference Committee meetings. However, it is realized that this is not always possible and discussion on the floor is then necessary.

We want the majority to rule but the minority to have every opportunity to be heard and to influence the House.

In an effort to expedite the meetings, nominations for all elected officers will be held on Saturday afternoon after the end of the third Reference Committee report. Voting will then take place in booths on Sunday morning for the adjournment of the House. Hopefully, this will help to expedite and eliminate confusion which in past years has occurred during the course of the election process. We are hopeful that this new procedure will allow the votes to be tallied more quickly and the House to be notified of the results in a more expeditious fashion.

We hope this new hotel and the new facilities will be conducive to a pleasant meeting with an enjoyable few days away from your practices. It is also hoped that the business of the Association will be expeditiously handled free from the turmoil and travail of the office and hospital practices through which we all exist.

God bless you and have a pleasant meeting.

The remarks of the Speaker of the House of Delegates were referred to Reference Committee III for consideration.

At this time, Dr. Perry proceeded to introduce FMA President, J. Lee Dockery, M.D.

Introduction of President

In the past several months we have seen our Association viciously attacked by nearly every branch of government. This is continuing and is apparently to be a way of life for the next several years. Fortunately the image of medicine in the state of Florida has been superbly defended by a diplomate extraordinaire. I am sure the training and the abilities that this man exhibited began in a small grocery store in Arkansas where he worked for his family. He continued his razorback way of life going to the University of Arkansas and then graduating from that University's School of Medicine.

After internship and residency at Jackson Memorial, Lee Dockery became a Floridian. He practiced in Dade County after his Air Force duties were completed where he received the Air Force commendation certificate, which I am sure is still hanging on the wall in his office. In the middle 1970s he and his family moved to Gainesville where he became a Gator and shortly after his arrival he was appointed as an Associate Dean of the University of Florida College of Medicine.

The real test has been the numerous problems thrust upon him as mentor of the Florida Medical Association during the last year. We have all seen where this state association has had more and more challenges and more complex, tangential areas of contention thrown upon it and associated with it than any other professional group in the history of the state of Florida and perhaps the United States.

With the prioritizing of our needs and desires, he has handled the special call that this presidency has placed upon him and he has handled it well. The goals, as difficult as they are, seem to be overcome one by one. Truly, a physician, a gentleman, a diplomat, and a dear friend who has helped all of us — his leadership has been outstanding. He has spent the year held aloft by the wings of man, flying more than any other physician in the history of the Florida Medical Association.

May I present to you J. Lee Dockery, M.D., 107th President of the Florida Medical Association.

Dr. Dockery addressed the House (the text of Dr. Dockery's remarks appears on page 531.)

Dr. Dockery was then asked to assume the Chair to present the A.H. Robins Award for Outstanding Community Service by a Physician. Dr. Dockery introduced Mr. Edwin D. Hood, a representative of the A.H. Robins Company, and announced that Dr. Hampton L. Schofield Jr. of Vero Beach, Florida was the recipient of the award. Dr. Dockery requested that Dr. Michael B. Zimmer and Dr. Randall D. Bertolette, of Indian River County escort Dr. Schofield to the podium to receive the award.

A.H. Robins Company Award For Outstanding Community Service By A Physician

Hampton L. Schofield, M.D., a practicing pathologist in Vero Beach, Florida, for the past 26 years, has been selected by the Board of Governors of the Florida Medical Association, upon nomination of the Indian River County Medical Society, as the recipient of the 1984 A. H. Robins Company Award for Outstanding Community Service by a Physician.

A native of South Carolina, Dr. Schofield received a Bachelor of Science degree from Rollins College in Winter Park, Florida. He spent two additional years in graduate study and then became an instructor of science and mathematics at Lakeview High School and Orlando Senior High School in Orlando, a position he remained in for eleven years. He decided to attend medical school and became a student of the Medical College of South Carolina. He received his medical degree in 1950 at the age of 41, later interning at Orange Memorial Hospital and completing residencies in pathology at the Medical College of South Carolina and at Orangeburg Regional Hosital in South Carolina.

In 1958, Dr. Schofield moved to Vero Beach to become pathologist and Director of the Laboratory of Indian River Memorial Hospital. In the quarter century since his arrival in Vero Beach, he has made numerous contributions to the betterment of that community.

Deeply concerned with the quality of education for young people, Dr. Schofield serves on the Board of Directors for Higher Education and Campus Ministries at Florida Southern College and is also a member of the President's Council there. He has served on the School Advisory Committee of the Vero Beach Senior High School since 1967.

Dr. Schofield supports many educational funds and programs and helped institute the Medical Laboratory Technician Program at Indian River Community College. His guidance is personally sought by many of the young people he has befriended over the years and through the local church, he has provided funds to assist young people to continue their education. Many of those he has helped have returned to productive roles in the community.

Dr. Schofield has made substantial gifts to the Charles and Kay Thrift Scholarship Fund at Florida Southern College and has substantially supported the work of the college's choir. The red blazers all the choir members wear were the personal gift of this year's Community Service Award recipient.

A respected member of the First United Methodist Church in Vero Beach, he has served on many boards of the church, is a lay pastor and often fills the pulpit in the absence of the minister.

Dr. Schofield has served on the Community Mental Health Clinic Board since 1969 and was its President for two years. He has also served on the Vero Beach Community Theater Trust since 1967 and as its Chairman was instrumental in the construction of the Riverside Theater.

An active member of the Exchange Club, he has been a board member as well as its President and Vice President. In 1963, he was selected as Exchangite of the Year. From 1964-1967, he was the Florida District Exchange Club President, Vice President and Treasurer. He also helped institute a program through the school system for senior students giving recognition to the Exchange Club Boy and Girl of the Month and at the end of the school year, the Girl and Boy of the Year. Last year he was given the "Honorary Lifetime Membership in the Exchange Club." In 1980, he was recognized by that organization by having his name placed in their "Book of Golden Deeds."

In local medical circles, Dr. Schofield quickly became known for the efficient blood bank he directed. In 1971, he was asked to be an inspector for the Florida Association of Blood Banks, a role he continues to fill.

As a licensed private pilot, Dr. Schofield has often flown to Orlando when the blood bank was in need of more blood, and he has transported many ill patients to distant medical centers when called upon.

In 1971, Dr. Schofield was appointed by the then Governor Askew as the Medical Examiner for District Nineteen. He then organized the Medical Examiner's program for four counties and continued as District Medical Examiner until 1983. From 1958-1971 he performed legal autopsies for the four-county area. He also was appointed by the Federal Aviation Administration as its Airplane Death Investigator and was licensed by the FAA to perform flight physicals as well.

Dr. Schofield and his wife, Frankie, have been married for 50 years.



Each year the AH Robbins Company sponsors an award honoring an FMA member for "Outstanding Community Service by a Physician." This year's recipient was Hampton L. Schofield, M.D., of Vero Beach (right), who was presented the award by Mr. Edwin D. Hood.

Dr. Dockery proceeded to announce that Mr. Harry Sudakoff of Sarasota, Florida was the recipient of the 1984 Distinguished Layman Award. Mr. Sudakoff was escorted to the podium by Dr. Richard M. Morrison and Dr. Robert E. Windom of Sarasota County.

Distinguished Layman Award
Mr. Harry Sudakoff

Whereas, Harry Sudakoff of Sarasota, Florida, has been a tireless and generous supporter of Florida philanthropic and humanitarian causes since he retired as a builder and financier and moved to the state in 1961; and

Whereas, His donation of $500,000 to the Sarasota Memorial Hospital Foundation, enabled the development of an open-heart surgery program which began in 1983, when previously patients in need of heart surgery had to be flown to Tampa; and

Whereas, This distinguished individual gave $250,000 to the Sarasota Memorial Hospital for a cardiac intensive care unit; and

Whereas, He supported the opening of a Senior Citizens Health Center in Sarasota; and

Whereas, Mr. Sudakoff donated enough funds for an infrared sound listening system to be installed in Sarasota's Van Wezel Performing Arts Hall to aid the hearing impaired; and

Whereas, This kind man is a member of the Board of Directors and is a strong supporter of the local United Way; and

Whereas, Mr. Sudakoff donated funds to New College for the construction of a multi-purpose auditorium and is a Trustee of the New College Foundation; and

Whereas, This benevolent individual has given generously of his time and money to Sarasota Boy Scouts, Boys Clubs, Girls Clubs and the Big Brothers organization; and

Whereas, This native of New York became the first Floridian to receive the Gold Medallion from the National Conference of Christians and Jews, the organization's highest honor; and

Whereas, Mr. Sudakoff is a recipient of the Milton Weill Human Relations Award of the American Jewish Community, presented for his many philanthropic and cultural endeavors in Sarasota; and

Whereas, Mr. Sudakoff is a staunch supporter of the Young Mens Christian Association, the Asolo Theater and Opera, the Ringling Museum and the Florida West Coast Symphony; and

Whereas, He is active in the United Jewish Appeal and the Anti-Defamation League of B'Nai B'Rith, the Sarasota Jewish Council and Temple Emanu-El; and

Whereas, Mr. Sudakoff continues to serve his community with his talent, energy and time; therefore be it

RESOLVED, That upon unanimous vote of the Board of Governors, the Florida Medical Association at its 110th Annual Meeting in Lake Buena Vista, Florida, May 2-6, 1984, presents to Harry Sudakoff its Distinguished Layman Award.

Malpractice Prevention Award

One very important award — the Malpractice Prevention Award — provides not only the Florida Medical Association, but also the Florida Physicians' Insurance Reciprocal, with an opportunity to express sincere appreciation to one of our colleagues for efforts extended on behalf of malpractice prevention.

This year's recipient was chosen by your Board of Governors for many, many reasons. He has devoted hours upon hours of his valuable time attempting to bring about changes in Florida's tort system to resolve the medical malpractice crisis, that as you well know, threatens the practice of medicine. This service clearly demonstrates his great devotion to medicine and to his fellow physicians.



Mr. Harry Sudakoff, Sarasota, receives the Distinguished Layman Award from Dr. J. Lee Dockery, FMA President.

The person of whom I speak, of course, is Dr. T. Byron Thames, of Orlando, who is Chairman of the FMA Committee on Professional Liability. Among his many activities in the area of medical malpractice, he served on the Insurance Commissioner's Task Force on Medical Malpractice. He also has been a member of the Reciprocal's Advisory Committee since 1978.

Dr. Thames is not only blessed with an exceptional intellect and a warm personality, he also is a talented and articulate spokesman. This is why he has served us so well on the various committees, at newspaper editorial board meetings to explain the medical malpractice crisis, responding to calls from reporters on this crisis and in debates with trial attorneys at public forums and on television.

So it is for these things and much, much more that we present this award to Dr. Thames.

Medical Speakers Awards

The medical profession in Florida has benefited in recent years from increased activity on the part of county medical societies and physicians in health-related television and radio programs. Because this type of activity is encouraged by FMA, we have established an annual awards program to recognize some of these outstanding programs and the people who have made them successful. The award consists of a plaque and a check for $100.

The First Place award for Organizational Television was presented to South Miami Hospital, which was nominated by the Dade County Medical

Association. Their program, entitled *Health Matters*, consisted of a 26-week series on health education that appeared on Public Broadcasting Station WPBT, Channel 2, at 6:30 p.m. on Sundays. A total of 51 members of the South Miami Hospital medical staff appeared in the 26-week series. The two tapes submitted in the contest, "Breast Cancer" and "Smoking and Your Health," were labeled as outstanding by the panel of judges and the series proved so popular that Channel 2 has decided to rerun the 26 episodes.

A Second Place award was presented to the Palm Beach County Medical Society for their program, *Call The Doctor*.

The First Place award for Individual Television Performance was presented to Dr. Joseph P. Fiore, President of the Lee County Medical Society. This program was one of several successful communications projects undertaken by the county society to improve relations between the media and medical profession in that section of the state.

In August of 1983, Dr. Fiore began a series of weekly medical news segments which have appeared on the Fort Myers CBS affiliate, WINK, Channel 11. The segments are aired regularly as part of the local nightly news, assuring them of a large viewing audience. Dr. Fiore has devoted from eight to 16 hours a week personally to this program. The response, according to WINK news executive has been extremely gratifying.

The Organizational Radio award category was presented to a repeat winner, the Duval County Medical Society, for its listener call-in program that is broadcast weekly over WEXI Radio in Jacksonville. From January 4, 1983 through December 27, 1983, 52 programs were broadcast which featured 39 physicians covering subjects ranging from anesthesiology to urology.

The Individual Radio award was presented to Dr. Bernard Kimmel of the Palm Beach County Medical Society who was nominated by his medical society for the award. Radio station WJND carried this weekly program which was entitled, *Doctor On Call*. It was a call-in talk show that extended for two hours with Dr. Kimmel fielding any and all medical questions. There were 32 of these programs aired during 1983, representing a large amount of free medical advice, which explains why this program was popular with WJND listeners.

Special recognition was presented to Dr. Arnold L. Tannis of Hollywood for his outstanding program in this category. Dr. Tannis was nominated by the Memorial Hospital medical staff in Hollywood.

Special thanks were extended to other medical groups around the state who submitted entries. For their efforts in helping to improve the image of the medical profession, we are grateful.

At this time, Dr. Dockery presented the Harold S. Strasser, M.D., Good Samaritan Award to Lawrence B. Robbins, M.D. of Miami Beach.

Accepting for Dr. Robbins was Dr. Edward R. Annis.



T. Byron Thames, M.D., of Orlando, receives the Annual Medical Malpractice Prevention Award from President J. Lee Dockery, M.D.

Harold S. Strasser, M.D.
Good Samaritan Award
Lawrence B. Robbins, M.D.

Whereas, Lawrence B. Robbins, M.D., of Miami Beach, Florida, has upon two notable occasions demonstrated exemplary humanitarian efforts unselfishly and to the benefit of his fellow man without concern for his own safety, welfare or comfort; and

Whereas, In 1975, when an explosion at a Miami Beach restaurant sent 108 victims to Miami's Mount Sinai Medical Center, this outstanding physician triaged the victims and was responsible for the treatment of 23 major burn cases; and

Whereas, This unselfish individual spent three continuous days and nights at the medical center treating the victims of the tragedy through the critical phase of their care; and

Whereas, While on a skiing vacation in Vail, Colorado, Dr. Robbins witnessed the collapse of a man who was waiting in a ski lift line and recognizing that the man had suffered a cardiac arrest, immediately began resuscitation efforts; and

Whereas, Dr. Robbins performed cardiopulmonary resuscitation, mouth-to-mouth resuscitation and cardiac massage until the Ski Patrol arrived; and

Whereas, He continued to assist in the 45 minutes of resuscitation efforts and accompanied the victim to a nearby medical center; and

Whereas, Dr. Robbins received a letter of commendation and praise from Vail associates; and

Whereas, This distinguished individual is the voluntary Chief of Plastic Surgery at Mt. Sinai Medical Center where he provides care to both private and indigent patients; and

Whereas, Dr. Robbins established a plastic surgery fellowship and was the consulting plastic surgeon for the Elk's Childrens Clinic in Miami; and

Whereas, He sponsors fellowships for medical students from all over the world and offers students trained in general and plastic surgery an additional year of special training in cosmetic surgery while compensating them for their assistance; and

Whereas, Dr. Robbins was born in White Plains, New York, and is a graduate of Emory University and of the University of Miami School of Medicine where he received his medical degree in 1963; and

Whereas, Dr. Robbins is a Diplomate of the American Board of Plastic and Reconstructive Surgery, a Fellow of the American College of Surgeons and a member of twelve professional medical organizations; therefore be it

RESOLVED, That upon the unanimous vote of the Board of Governors, the Florida Medical Association at its 110th Annual Meeting in Lake Buena Vista, Florida, May 2-6, 1984, present to Lawrence B. Robbins, M.D., the first Harold S. Strasser, M.D., Good Samaritan Award with sincere appreciation for his humanitarian acts on behalf of his fellow man.

1984 Awards For Excellence In Medical Journalism

Dr. Dockery then presented the Seventh Annual Florida Medical Association Awards For Excellence in Medical Journalism. This past year was an exciting and eventful one in the field of medicine, actively covered by journalists all over the state. How eventful is illustrated by the entries in this awards contest which cover a broad range of subjects from hypnosis to pharmacology, and from weight control to cancer. New life-saving treatments made possible by modern medical technology were brought into public view, as were the issues of euthanasia and "Death with Dignity." The timely subjects of rising health care costs and ways to combat them were covered extensively by our state's medical writers.



Edward R. Annis,M.D., accepts the Harold S. Strasser, M.D. Good Samaritan Award on behalf of Lawrence B. Robbins, M.D.

The purpose of this awards program is to recognize and thank journalists for their efforts and to encourage outstanding and responsible medical reporting.

The 65 entries were judged by two panels of judges. The newspaper and magazine articles were judged by Dr. James W. Walker, Dr. Clyde M. Collins and Dr. Guy T. Selander, all of Jacksonville, and Dr. F. Norman Vickers of Pensacola. The radio and television categories were judged by Dr. Selander, Dr. Collins, Dr. Charles B. McIntosh, of Jacksonville, and FMA Director of Communications, Mr. Robert Williams.

Due to time restraints, only First Place winners were invited to the First House of Delegates for these presentations. Second Place and Honorable Mention awards were sent to county medical societies for local ceremonies at a later date. First place in each of the six categories carries with it a trophy and a check for $500. The winners are as follows:

In the Radio category, the judges agreed that this year's best entry was a series entitled, "AIDS: Facts or Fear?" by Kira Grishkoff of WGBS Radio in Miami.

In recent years, we have witnessed many shocking and terrifying acts of violence in the United States. Society was horrified by the assassination attempt of President Reagan and of other important figures, but we discovered that not only the famous are victimized when last year several patrons and employees of a Tampa grocery store were burned with gasoline by an individual suffering from mental illness. This leads us to ask why certain mentally disturbed people are not discovered until a tragedy occurs. In attempting to address this question, Kathy McClintock of WINK Television in Fort Myers developed a five-part series entitled, "Walking Time Bombs." For her outstanding efforts, the judges awarded her First Place in the Television category.

Methadone has been called the treatment for chemical abuse on one hand and just a substitute for illegal drugs on the other. Fred Shulte of the *Fort Lauderdale News and Sun Sentinel* explored this issue in a series of articles called "Methadone: The Deadly Cure," and in doing so, won First Place for Newspapers with over 50,000 circulation.

A monthly series entitled, "Your Health," covering such subjects as braces, kidney stones, senility, herpes simplex virus and AIDS, won First Place for Daily Newspapers with circulation under 50,000. The column was written by staff writers for the *Vero Beach Press - Journal*. Editor, Sam Rohlfing, accepted the award.

Mr. Gene Casey, as editor of the *Charlotte Sun*, a weekly newspaper in Charlotte Harbor, engineered a 10-part series dealing with home and hospital care. Entitled, "Special Report: Health Care," the series was written by members of the *Charlotte Sun* staff, including Mr. Casey. The judges felt it was this year's best entry in the weekly Newspaper category, and awarded it First Place.

The loss of an arm or leg is a tragedy, but the courage of the victims of amputations enables them to overcome the loss. Such was the case of 22-year-old Missy Koch, of Miami, once an athlete whose leg was amputated because of cancer. Steve Sternberg wrote her story in the *Miami Health Tropic Magazine*, and in doing so won First Place in the Magazine category.

The "Best of Contest" for the Awards for Excellence in Medical Journalism, and well-deserving of a second recognition, was awarded to Kathy McClintock of Ft. Myers for her television entry "Walking Time Bombs."

The President then called Dr. Daniel B. Nunn, Editor of *The Journal of the Florida Medical Association, Inc.*, to the platform to present the awards for the Seventh Annual JFMA Awards Contest for County Medical Society Bulletins.

Winners of Seventh Annual JFMA Awards Contest For County Medical Society Bulletins

Category I: General Excellence

First Place: *The Bulletin of the Hillsborough County Medical Association,*
John Perchalski, M.D., Editor

Special Citation: *The Stethoscope* (Volusia County)
Remigio G. Lacsamana, M.D., Editor

Category II: Most Improved Bulletin

First Place: *Palm Beach County Bulletin*
Stephen N. Martyak, M.D., Editor

Category III: Best Editorial

First Place: *Marion County Bulletin*
H.L. Harrell Jr., M.D., Editor

Special Citation: *Lee County Bulletin*
Francis L. Howington, M.D., Co-Editor
Michael E. Steier, M.D., Co-Editor

Category IV: Best Regular Feature

First Place: *Miami Medicine*
Daniel L. Seckinger, M.D., President

Special Citation: *Capital County Newsletter*
James K. Conn, M.D., Editor

Special Citation: *Polk County Bulletin*
John W. Glotfelty, M.D., Editor

Category V: Special Recognition

First Place: *Escambia County Bulletin*
F. Norman Vickers, M.D.

Special Citation: *Sarasota County Newsletter*
Richard M. Morrison, M.D., Editor

Sanford A. Mullen, M.D., Award

President Dockery called on C. Fenner McConnell, M.D., to present the third annual Sanford A. Mullen, M.D., Award. Dr. McConnell presented the award to Thomas Purcer Wood, M.D., a pathologist at Tallahassee Memorial Medical Center. Dr. Wood is Past President of the Florida Society of Pathologists and has served on the Florida Medical Association Committee on Legislation since 1976. He is a delegate to the College of American Pathologists and is past president of the Capital Medical Society and past chairman of the medical staff at Tallahassee Memorial Hospital. Dr. Wood is an active Rotarian and is involved with the Boy Scouts of America, having received the Silver Beaver Award.



Dr. C. Fenner McConnell, Pensacola, presented the Third Annual Sanford A. Mullen Award to Thomas Purcer Wood, M.D., of Tallahassee.

Ten County Bulletins Honored



Ten county medical societies received plaques in the Seventh Annual Journal of the Florida Medical Association Awards Contest for County Medical Society Bulletins. For the first time, awards were presented at the annual Editor's Dinner. First Place Winners include (1) F. Norman Vickers, M.D., Editor, Escambia County Medical Society Bulletin accepts the Special Recognition Award. (2) Pat Driscoll, Hillsborough CMS Director of Communications accepting the General Excellence Award on behalf of the Hillsborough County Bulletin. (3) Lee A. Fischer, M.D., President of Palm Beach County Medical Society accepts the Award for Most Improved Bulletin. (4) Henry L. Harrell Jr., M.D., Editor of the Marion County Bulletin accepts the award for Best Editorial. (5) Daniel L. Seckinger, M.D., President, Dade County Medical Association accepts the award for Best Regular Feature in Miami Medicine.









Presentation by Auxiliary President
Mrs. S. Bruce (Priscilla) Gerber

Dr. Dockery, members of the Board of Governors, Delegates and friends, we have had a wonderful Auxiliary year and it is with great pride that I report to you today on the accomplishments of our Auxiliary. Before I do all my bragging, I would like to compliment the physicians for their interest and concern about the House of Medicine and tell you that I think that the citizens of Florida are fortunate to have such outstanding medical care. We have spent the year spreading that message. The Auxiliary's main focus this year has been on our public relations program.

We took our story to the public to show them that the spouses of physicians, as well as the physicians of Florida care about the health in their community and volunteer their time to promote good health. We began the year with a statewide media day to inform the members of the media about what the Auxiliary does. We were an overwhelming success; in fact, the AMA Auxiliary will be having national media days similar to what we had here in Florida. We think that is quite a compliment. We blitzed the state with public service announcements on radio and television and sponsored a cartoon strip, "The Hasty Family." Hasty, H-A-S-T-Y, stands for "Health and Safety Tips For You," and it was a vehicle for calling attention to vital messages of health and safety. Our cartoon strip was well received in classrooms all across Florida.

Our best public relations tool, of course, is the amount of time we spend volunteering in our communities. This year the Auxiliary participated in over 250 projects and programs across the state of Florida, from breast self-examination and CPR classes to infant safety seat projects, substance abuse prevention and child abuse prevention programs, as well as programs for the aging and many, many more.

Our voice is being heard — we are making a difference. We are a force of nearly 6,000 strong and the second largest state auxiliary in the nation. We invite all spouses who are not already members to be a part of our work and fun. Our membership this year has increased enough to give us two more delegates to the AMA Auxiliary national convention this summer in Chicago — we were thrilled. Tomorrow we will charter three new county Auxiliaries, and we are very thrilled about that, too.

Our fund raising efforts have reached an all-time high. Donations to AMA-ERF have exceeded the $112,000 dollar mark, and I understand we are the first in the nation on contributions to that fund.

We have also contributed to the Florida Medical Foundation to which thousands of dollars have gone towards the Impaired Physicians Program. The Auxiliary has been a strong supporter of this program in many ways, including fund raising.

It is hard for me to believe my term of office is over. Part of me wishes it could go on forever, but another part can hardly wait to turn the responsibilities over to someone else. It has been a year of innovation, activities and accomplishments and I am very proud of the Auxiliary. Dr. Dockery has been a strong supporter of the Auxiliary and because of his cooperation, understanding and faith in our goals, we have been able to achieve what we have. Thank you so much, Dr. Dockery to you and the entire Board of Governors. You were outstanding to work with and I was privileged to work with you. I would also like to thank Mr. Donald Jones and the entire FMA staff. Their dedication and help have been vital to our success. Most importantly, I would like to thank my husband, Bruce, and our four sons for their love and patience, understanding, help and support this entire year.

Thank you.

Dr. McKechnie, Vice Speaker, then introduced distinguished guests, including Rufus K. Broadaway, M.D., AMA Trustee; Edward R. Annis, M.D., AMA Past President; Mr. Whalen M. Strobhar, AMA Deputy Executive Vice President; Mr. William Flaherty, President, Blue Cross and Blue Shield of Florida, Inc., Jacksonville; James W. Walker, M.D., Past Officer of FMA and President of PIMCO; Mrs. Priscilla Gerber, President, FMA Auxiliary; Mrs. Nancy Smith, President-Elect, FMA Auxiliary; Mrs. Edie Epstein, Southern Regional Director, AMA Auxiliary; and Mrs. William Reardon, President, Southern Medical Association Auxiliary.

Dr. McKechnie then introduced Mr. Roy Pfautch, President of Civic Service, Inc. and FMA public relations consultant, who presented a special report on the constitutional revision campaign.

Mr. Roy Pfautch
President, Civic Service, Inc.

Thank you, Mr. Speaker. It is not my role to inspire you or activate you into this campaign, but rather it is my role to thank you for this opportunity as an outside consultant to have the privilege of addressing this House, albeit briefly, and to bring you an interim report as to what has occurred since this House so courageously approved a program of action at your special meeting. Of course, the next report that will be made to this House, per se, will hopefully be a victory report after November 6.

You will recall that this House in its wisdom has authorized a plan of action which is to be bound by professionalism and hopefully by a bringing into play the most advanced scientific, sophisticated techniques available for reaching the voters of Florida. I want to report to you that working through the committee which your Board of Governors has established and through President Dockery and Mr. Jones, that we have created the organization which we believe will bring to fruition the plans you have in mind. The basic framework for this organization is now in place in Jacksonville and I would like to present to you the individuals whose political experience and whose wisdom and understanding of the process of involving people in the political arena, I think is far superior to that which one would normally find in a statewide initiative campaign. I am excited that these individuals have come from various places to Florida to involve themselves with you in this crusade, and I think you will be excited by the dimensions of leadership and guidance and hard work that they put forth in your behalf in the coming months. This very professional team is headed by an individual who is from Miami and so knows your state very well. He was Democratic National Committeeman for a number of years from Florida. He was most recently the National Director of the Cranston for President campaign and for a good Republican like me to recommend a Democrat like that, you know he obviously has to have the ability which it takes. It is a pleasure to present to you Mr. Sergio Bendixen. He has moved back here from Washington and established residence in Jacksonville and he will be ably assisted on his executive team by Karen Kapler, Kam Kuwata, and Frances Hightower. We are enrolling additional members of this framework and of this foundation team and they hope to have their plan of action in place and moving very shortly. Sergio has been with us since the first of April. They are putting into place the basics of this plan of operation for which you have such high hopes.

I want to say to you, however, that it is very important and I think this House is sympathetic to it, that many of the actions and elements of success that you would like to see taking place right now, Mr. Speaker, will not be seen for some time. You were willing to embark upon a professional vote-counting, making-the-shots-matter operation. You told us that very bluntly when you met in your special session. The time to win this battle is on November 6 and not with some publicity or some high profile dimensions at this particular juncture. So I encourage you not to get nervous. I want you to be anxious, but on the other hand, let us not throw away victory in November for some kind of instant perception in April or May. That is somewhat what we are about because we really have four phases to this operation and the first phase is obviously the obtaining of the signatures necessary to put this particular initiative on the ballot. Without that, we cannot vote in November. That is a little different than if we were running a candidate for office.

The second phase, which Mr. Kuwata is heading, is to enlist and to excite the attention of the opinion leaders in Florida for this undertaking in which we are involved. While we would like to think that power in a democracy flows up from the people and out, we know it to be true that it basically comes down from a matrix of opinion leaders and then makes itself felt throughout the body politic. So for the next two or three months, Mr. Kuwata will be leading a program to involve the leadership opinion of the state in all elements of life throughout many layers of society, involving many of you in reaching those individuals so that when we do go public, we have that kind of foundation on which to rest. At the same time, a third phase of this operation will be working with the Auxiliary. This professional team recognizes the power that is present in the Florida Auxiliary and what can be accomplished when they put their spirit, hearts and actions into this fray. All of this will lead us to the final exposition which is obviously to go public which I would not anticipate to be until after Labor Day. At that point, we want to be in place and ready for action. We want to be sound and we want to be solid and this is what we are about with the professional team who has come into your midst.

I say to you that you have the wisdom and the courage and I do not know many associations with whom I have dealt who would have that kind of real sophistication as to the problem or the challenge we face. In making possible through your finances and through your understanding of the process, you have been willing to put this kind of political team into action. However, I also want to caution you that there is a second dimension and some of you have suggested to me that perhaps you did not understand this dimension when we last talked together, so I want to underscore it today. I think it is just as important in the midst of all the professionalism and all the finances and all the kind of operation that we are bringing into being in your name, and that is the role in which the medical community plays in this particular endeavor. I think Mr. Bendixen would join me and agree that with all the so-called magic that we have in today's political techniques, that we still cannot get away from the dimension of people.

The dimension is self involvement in any successful endeavor. Some of you have asked me, "Well, if we have all of this professional operation, why should we be concerned with signing petitions in our office?" Well, obviously, Mr. Bendixen is building a very successful framework in which to gather petition signatures throughout the congressional districts of Florida and obviously this is being run on many of the proven techniques with which he has experience and which have worked for other causes. Just as obviously we recognize that with the spirit that was in this House and is in this profession with 14,000 members — plus 6,000 in the Auxiliary — obviously if only 10% or 2,000 are committed to this cause, that is a heck of a dimension of peopledom for us not to throw away. If we are being professional in your behalf, then obviously we are going to turn back to you to be a part of that whole framework. I recall when the very successful campaign was run in California by the cigarette industry to defeat an initiative which would have limited the right to smoke. The first thing that industry did was to determine whether or not their own family was in order. Obviously that industry had all the money and the wherewithal to create the most professional operation possible. Equally obvious, that industry recognized that if their own "tabacco family," in this case their dealers and their suppliers and the people who worked in their factories and their salesmen, etc., were not committed to it, there was a weakness — a very definite weakness — in that link of communication with the public that they were trying to reach.

I suggest to you to look at the climate in which we are existing. It is very, very much encumbent upon us to turn back to you and to remind you that in the midst of all this professionalism which you want reared in your behalf, that there is a very important and precious role for this Association's membership and particularly this House to play. If I were preaching a sermon, I would always try to throw a hooker in which somehow gives you a dimension of what I am talking about. I am reminded of that marvelous quote which always says something to me as a political activist. I think to paraphrase it, it went "The trouble with all of the computer magicians with their dreams of eons of power, is that they forget the untold megaton force in one truly committed human soul." I have confidence that Mr. Bendixen's operation is going to report to your Board and to your President at that time, Dr. Coleman, and to the committee that you have reared in your behalf during each stage of this campaign of what is being accomplished in your behalf in terms of the wider political context. I have equal confidence that not because you must, but because you will, that this House and this membership and this Auxiliary are going to be a part of this campaign.

The first step is obviously the petitions. The second step is taking part in the briefings which I understand Mr. Bendixen has scheduled for 2:00 on Thursday and at 4:15 on Friday so that you can be a part of the dimensions that he wants to create in your behalf. This is going to be an exciting time. You are doing something which no state medical society that I am aware of, or many professional associations, have taken upon themselves. I think that it is from my relationship with you over the past six or seven years, that it is very much part and parcel of the spirit of this association. I think it is your participation which will ennoble this campaign. I think it is your participation which will give it meaning to the people that you are going to serve in this cause, and to give the dimension which is the preservation of quality health care because that is really what we are about.

I am very much moved that this House would commit the kind of resources that you have. I do not know many associations that would dare to do it. I have equal confidence, Mr. Speaker, that when we meet again in November or December, we will be also congratulating you for the dimension of self involvement that you, delegates, and you, members and you, Auxiliary persons, put into this campaign.

Thank you.

Corrections to the Handbook were then announced by the Vice Speaker:

On Page 8, entitled "Reference Committees" under Reference Committee III, "Wilbur L. Dawkins, M.D." should read "Wilbert L. Dawkins, M.D."

Dr. McKechnie then announced the members of the Reference Committees, the assignment of AMA Delegates to the Reference Committees and the times that each Reference Committee would meet.

Reference Committee No. I
Health and Education

John M. Canakaris, M.D., Chairman, Flagler
Stephen R. Zellner, M.D., Lee
Alvin E. Smith, M.D., Volusia
Joseph Harris, M.D., Dade
Rex Orr, M.D., Pinellas
Jack W. MacDonald, M.D., (Alternate), Capital
AMA Delegate Advisor: Richard G. Connar, M.D.
(Alternate — William B. Deal, M.D.)

Reference Committee No. II
Public Policy

Margaret C.S. Skinner, M.D., Chairman, Dade
James T. Cook III, M.D., Bay
Kenneth C. Kiehl, M.D., Sarasota
Wallace M. Philips Jr., M.D., Orange
Thomas R. Civitella, M.D., Charlotte
Mark V. Barrow, M.D., (Alternate), Alachua
AMA Delegate Advisor: Robert E. Windom, M.D.
(Alternate — Joseph T. Ostroski, M.D.)

Reference Committee No. III
Finance and Administration

Paul A. Flaten, M.D., Chairman, Broward
Wilbert L. Dawkins, M.D., Duval
Robert E. McCammon, M.D., Hillsborough
A. Frederick Schild, M.D., Dade
Douglas R. Murphy, M.D., Sarasota
Richard J. Bagby, M.D., (Alternate), Orange
AMA Delegate Advisor: T. Byron Thames, M.D.
(Alternate — Vernon B. Astler, M.D.)

Reference Committee No. IV
Legislation and Miscellaneous

Fred S. Carter, M.D., Chairman, Martin
John H. Parker Jr., M.D., Taylor
Virgil A. Ponzoli Jr., M.D., Collier
Jesse Q. Sewell III, M.D., Monroe
Ernest G. Sayfie, M.D., Broward
Richard H. Ciordia, M.D., (Alternate), Escambia
AMA Delegate Advisor: Louis C. Murray, M.D.
(Alternate — Frank C. Coleman, M.D.)

Reference Committee No. V
Medical Economics

Robert H. Hux, M.D., Chairman, Lake
Samuel Atkinson, M.D., Okaloosa
Lee A. Fischer, M.D., Palm Beach
S. Peter Stokley, M.D., Dade
Wayne L. Godbold, M.D., Orange
Thomas M. Caswall, M.D., (Alternate), Polk
AMA Delegate Advisor: Joseph C. Von Thron, M.D.
(Alternate — Dick L. Van Eldik, M.D.)



President-Elect Frank C. Coleman, M.D. and Broward County Medical Society President Ernest G. Sayfie, M.D. smile for the Journal photographer.

Dr. McKechnie announced that the assignments of reports and resolutions to Reference Committees were as indicated in the Handbook.

The Vice Speaker announced the assignment of Supplemental Reports and Resolutions which were received too late for inclusion in the Handbook and which had been inserted into the Delegates packets as indicated on the reports.

The Speaker called for any reports which had been received too late to be included on the agenda.

Dr. Perry announced the dates and times of the Auxiliary Reception and Art Auction, Blue Cross and Blue Shield Informational Meeting, Florida Physicians Association Annual Membership Meeting, the General Session, Tee-off time for the Golf Tournament, the FMA Symposium, "The Health of the Public," the President's Party, the FLAMPAC/Auxiliary Luncheon, the Health Run and the "Reason 84" Campaign Briefing.

The House recessed at 5:30 p.m. to reconvene on Saturday, May 5, at 3:00 p.m.



FMA President J. Lee Dockery, M.D. and Speaker of the House James B. Perry, M.D. prepare for a session of the House of Delegates.

Tribute to Executive Vice President W. Harold Parham, D.H.A.

It was a gala evening as friends and colleagues of W. Harold Parham, D.H.A., expressed their appreciation for 35 years of dedication and service to the Florida Medical Association. (1) Immediate Past President Robert E. Windom, M.D., and Mrs. Windom (Lelia) demonstrate some of the latest steps on the dance floor. (2) AMA Deputy Executive Vice President Whalen M. Strobhar and Robert E. Windom, M.D., prepare for a jovial night out. (3) W. Harold Parham, D.H.A., takes a moment to thank his many friends and colleagues. (4) Dr. and Mrs. W. Harold Parham take the lead on the dance floor. (5) Mrs. Fred P. (Anne) Swing, Mrs. Frank C. (Ruth) Coleman and Mrs. Daniel B. (Gloria) Nunn. (6) Miss Myra Nunn and Mrs. Daniel B. (Gloria) Nunn pose for The Journal photographer. (7) President J. Lee Dockery, M.D. and Mrs. Barbara Dockery enjoy an evening away from the demanding activities of the House of Delegates. (8) AMA Delegates Eugene G. Peek Jr., M.D. and Joseph C. Von Thron, M.D., exchange a friendly handshake. (9) Mrs. Eugene G. (Buggie) Peek Jr.; Miss Mary Parham; Mr. Will Parham; President J. Lee Dockery, M.D.; Jack A. MaCris, M.D.; Mrs. Mary Parham; AMA Deputy Executive Vice President Whalen Strobhar and Robert E. Windom, M.D. (10) George S. Palmer, M.D., Tallahassee, pays tribute to his close friend, W. Harold Parham, D.H.A.


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General Session

The General Session of the 110th Annual Meeting of the Florida Medical Association, Inc., was called to order at 11:00 a.m. on Friday, May 4, 1984, in the Great Hall North of the Buena Vista Palace Hotel, Lake Buena Vista, Florida.

Dr. Dockery introduced the officers seated at the head table and then recognized certain distinguished guests: Mrs. K.E. (Virginia) Kutait, Director, American Medical Association Auxiliary, Southern Region; Mrs. William (Kay) Reardon, President, Southern Medical Association Auxiliary; Dr. Fred C. Rainey, Chairman, AMPAC; Dr. Rufus K. Broadaway, AMA Trustee.

Dr. Dockery then invited Dr. Eugene G. Peek, Jr., President of the Florida Medical Foundation; Mrs. Priscilla Gerber, President of the FMA Auxiliary; and Mrs. Joan Selander, AMA-ERF Chairman for the Auxiliary, to come to the podium for the presentation of grants from the AMA-ERF to medical school deans.

Checks were presented to Dr. William B. Deal, Dean, University of Florida College of Medicine; Dr. Azorides Morales, Professor and Chairman, Department of Pathology, University of Miami School of Medicine, representing Dr. Bernard J. Fogel, Dean of the college; Dr. James Hallock, Deputy Dean, University of South Florida College of Medicine, representing Dr. Andor Szentivanyi, Dean of the college; Dr. Robert Reeves, Director, Florida State University, Program in Medical Sciences.

After the presentations, Mrs. Gerber made a special presentation to Dr. Peek of a check for $5,000 for the Impaired Physicians Program of the Florida Medical Foundation.

Dr. Dockery then announced the winners of the 1984 Scientific Exhibit Awards.

1984 Scientific Exhibit Awards

First Place:

"Hawkins-Hunter Retrograde Nephrostomy Technique"
Irvin F. Hawkins, M.D., Gainesville

Second Place:

"Altdorf Hip Plate Fixation of Subtrochanteric Femoral osteotomies in Children"
Jorge E. Alonso, M.D, Jacksonville

Third Place:

"Child Abuse in Florida"
Helene Tanous, M.D, Lutz

Honorable Mention:

"Current Trends in the Postoperative Management of Idiopathic Scoliosis"
Charles T. Price, M.D., Orlando

"Coronary Revascularization in the Elderly Female"
David L. Galbut, M.D., Miami

"Environmental Health (Air, Water, Food) Umbrella Protection"
Robert D. May, M.D., New Port Richey



First place winner in the Annual Scientific and Educational Exhibits was Hawkins-Hunter Retrograde Nephrostomy Technique presented by Irvin F. Hawkins, M.D., University of Florida College of Medicine, Gainesville.

On behalf of Dr. Daniel B. Nunn, Editor of *The Journal*, Dr. Dockery announced the winner of the Editor's Award which is presented annually to the best entry in the FMA Auxiliary Art Show. This year's winning entry was a photograph, "Baby in Basket," taken by Miss Cindy Jarrell. The winning entry traditionally appears on the cover of the Proceedings Issue of *The Journal*.

Dr. Dockery then introduced the 1984 Abel S. Baldwin lecturer, Mr. Jules Bergman, ABC News Science Editor. Mr. Bergman began his remarks by stating that society is facing a ". . .real crisis, a crisis in confidence in ourselves, a crisis of credibility, and we are all near to totally disbelieving one another in this country." He went on to say that medicine is our single most explosive crisis and the media has contributed to the problem. Much of his criticism of medicine surrounded the lack of compassion he has observed. On the lack of compassion exhibited by today's interns and residents Mr. Bergman concluded that ". . .after they've been on duty 72 to 80 hours, it is all they can do to remember their name, rank and serial number, much less deal with each patient in a humane, caring manner."

Too many surgical procedures and unnecessary tests were cited as major contributors to the rising cost of medicine. The medical liability insurance crisis was recognized as a problem ". . .wildly out of control." Although the media has often been at fault in reporting medical breakthroughs which proved to be disappointing, the same media may be responsible for saving medicine by focusing our attention on our crises before they get out of control.



ABC News Science Editor Jules Bergman, presented the annual Baldwin Lecture.

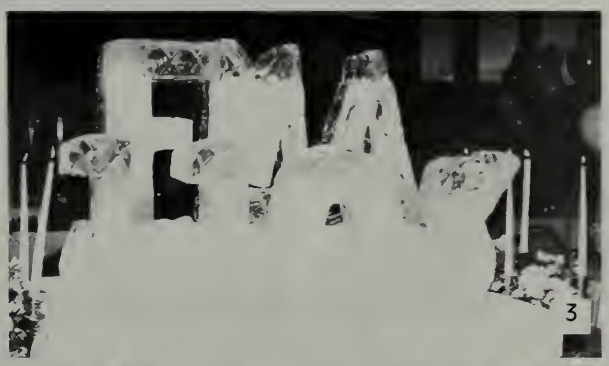
Although a real crisis exists, Mr. Bergman foresees a bright future when a real impact will be seen in the prevention and treatment of heart disease and cancer. The normal life span will reach to 95 years and two careers during a lifetime will be common. An interesting question and answer period followed Mr. Bergman's remarks.

President's Reception

(1) Incoming and outgoing leaders stand together with their wives at the Annual President's Reception. From the left are President-Elect Frank C. Coleman, M.D. and Mrs. Coleman (Ruth), Mrs. J. Lee (Barbara) Dockery and President Dockery. (2) President and Mrs. J. Lee Dockery (left) and FMA Executive Vice President Dr. and Mrs. W. Harold Parham. (3) The Florida Medical Association celebrated its 110th Anniversary in 1984. (4) Joseph T. Ostroski, M.D. and O. William Davenport, M.D. both of Miami, enjoy the party given at the President's Reception. (5) Council on Scientific Activities Chairman Henry M. Yonge, M.D. and Mrs Yonge (Pat). (6) Drs. Louis and Maria Perez enjoying the fun at the annual President's Reception. (7) Speaker of the House James B. Perry, M.D. and Mrs. Perry (Peg). (8) President and Mrs. J. Lee Dockery share a moment with former AMA President Edward R. Annis, M.D. (9) President J. Lee Dockery, M.D. welcomes DCMA President-Elect and Mrs. A. Frederick (Judy) Schild.


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Annual Meeting Highlights


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(1)Two familiar faces at FMA functions are AMA Delegate Burns A. Dobbins Jr., M.D. and Mrs. Dobbins (Estelle). (2) FMA President J. Lee Dockery, M.D. shows his usual appreciation for a humorous story. (3) President-Elect Frank C. Coleman, M.D. shares some thoughts with FMA Speakers Bureau Chairman and former AMA President Edward R. Annis, M.D. (4) President-Elect Frank C. Coleman, M.D. and AMA Trustee Rufus K. Broadaway, M.D. (5) Dick L. Van Eldik, M.D. from the Board of Governors chats with newly appointed Council on Medical Services Chairman Joseph T. Ostroski, M.D. (6) Vice-speaker Franklin B. McKechnie, M.D. of Winter Park did his usual outstanding job. (7) Speaker of the House James B. Perry, M.D. makes a strong finish in the "Health Run for Fun". (8) AMA Trustee Rufus K. Broadaway, M.D. of Miami is always on hand to offer support. (9) First lady Mrs. J. Lee (Barbara) Dockery listens to some confident prognostications from an enthusiastic Florida Gator. (10) Long time friends President J. Lee Dockery, M.D. and Past-president O. William Davenport, M.D. (11) Representing the Dade County Medical Association were Charles A. Dunn, M.D. (left) and Edward R. Annis, M.D. (12) Two friendly faces from the Duval County Medical Society, Charles B. McIntosh, M.D. (left) and former JFMA Editor Clyde M. Collins, M.D. (13) The Sixth Annual "Health Run for Fun" attracts its usual enthusiastic participants.


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Second House of Delegates

The Second Meeting of the House of Delegates convened at 3:00 p.m., Saturday, May 5, 1984, in the Great Hall North of the Buena Vista Palace Hotel, Lake Buena Vista, Florida, with Dr. James B. Perry, Speaker of the House, presiding.

Dr. Dolores A. Morgan of the Credentials Committee reported that 238 Delegates were present with 40 component county societies represented, constituting a quorum, and moved that the Delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; Mark V. Barrow, M.D.; Thomas D. Bartley, M.D.; William B. Deal, M.D.; Charles P. Gibbs, M.D.; William T. Hawkins, M.D.; D. Orvin Jenkins, M.D.; Mr. James B. Dolan, Student Delegate.

BAY — James T. Cook III, M.D.; (Absent — William G. Bruce, M.D.; B. Philip Cotton, M.D.)

BREVARD — Raymond A. Armstrong, M.D.; Richard I. Barr, M.D.; James E. Carter, M.D.; Walter A. Cerrato, M.D.; Robert C. Ufferman, M.D.; Ovidio E. Vitas, M.D.; Joseph C. Von Thron, M.D.

BROWARD — Bruce B. Burgess, M.D.; Andre S. Capi, M.D.; Philip A. Caruso, M.D.; David A. D'Alessandro, M.D.; Arthur L. Eberly, M.D.; George Edwards, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; Theodore W. Hahn, M.D.; Wilbur F. Helmus, M.D.; Theodore C. Lescher, M.D.; George P. Messenger, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Ray E. Murphy Jr., M.D.; Donald J. Plevy, M.D.; Ernest G. Sayfie, M.D.; Richard D. Shafron, M.D.; Marvin L. Stein, M.D.; H. Murray Todd, M.D.; Alan J. Yesner, M.D.; (Absent — William C. Hartley, M.D.; James A. Jordan, M.D.; David C. Lane, M.D.; Joseph Sachs, M.D.; Richard D. Schultz, M.D.; Peter A. Tomasello, M.D.; Anthony J. Vento, M.D.; Juan S.A. Wester, M.D.)

CAPITAL — Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Robert N. Webster, M.D.

CHARLOTTE — Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; (Absent — Jaime Torner, M.D.)

CITRUS — Alexander E. Hlivko, M.D., W. Randall Jenkins, M.D.

CLAY — Hinson L. Stephens, M.D.; (Absent — Clarence M. Harris, M.D.)

COLLIER — Charles J. Montgomery, M.D.; Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.

COLUMBIA — Leela Swamy, M.D.

DADE — Edward R. Annis, M.D.; Jerome Benson, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; Harlan S. Chiron, M.D.; Vincent P. Corso, M.D.; O. William Davenport, M.D.; Norman T. Ditchek, M.D.; Charles A. Dunn, M.D.; Richard J. Feinstein, M.D.; Miguel Figueroa, M.D.; N. Ralph Frankel, M.D.; Richard L. Glatzer, M.D.; Alan S. Graubert, M.D.; Joan Harris, M.D.; Joseph Harris, M.D.; James J. Hutson, M.D.; Jesse G. Keshin, M.D.; Maurice H. Laszlo, M.D.; Warren Lindau, M.D.; Simon E. Markovich, M.D.; Dolores A. Morgan, M.D.; Sheldon D. Munach, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; William I. Roth, M.D.; Arnold F. Schild, M.D.; Daniel L. Seckinger, M.D.; Barry M. Seinfeld, M.D.; Margaret C.S. Skinner, M.D.; Samuel P. Stokley, M.D.; Chauncey M. Stone, M.D.; J. Richard Taylor, M.D.; Osvaldo D. Valdes, M.D.; Edgar W. Webb, M.D.; Harold H. Weiner, M.D.; Sheldon Zane, M.D.; Ms. Ana Isabel Gonzalez, Student Delegate; (Absent — Jose S. Bocles, M.D.; Richard C. Clay, M.D.; Joseph H. Davis, M.D.; Norman M. Kenyon, M.D.; Jose F. Landa-Gutierrez, M.D.; Carlos G. Llanes, M.D.; Morton L. Miller, M.D.; Charles A. Monnin Jr., M.D.; Miguel A. Mora, M.D.; Jose R. Pujols Bosch, M.D.; Pedro A. Ramos, M.D.; Everett Shocket, M.D.; George A. Simpson, M.D.; Douglas Slavin, M.D.; Marvin B. Slotkin, M.D.; Charles F. Tate, M.D.; Steven M. Weissberg, M.D.; Edmund K. Zahn, M.D.)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Samuel J. Alford Jr., M.D.; Clyde M. Collins, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; William J. Garoni Jr., M.D.; Walter A. Harmon, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; John F. Lovejoy Jr., M.D.; Kevin M. McAuliffe, M.D.; Charles B. McIntosh, M.D.; Guy T. Selander, M.D.; Seabury D. Stoneburner Jr., M.D.; Robert H. Threlkel, M.D.; George S. Trotter, M.D.; James W. Walker, M.D.; William D. Walklett, M.D.; (Absent — Gaston J. Acosta-Rua, M.D.; Harvey E. Bernhardt, M.D.; Daniel B. Nunn, M.D.)

ESCAMBIA — Richard H. Ciordia, M.D.; Charles J. Kahn, M.D.; Theodore J. Marshall, M.D.; Charles F. McConnell, M.D.; Michael R. Redmond, M.D.; Robert K. Wilson Jr., M.D.; Henry M. Yonge, M.D.

FLAGLER — John M. Canakaris, M.D.

FRANKLIN-GULF — (Absent — Joseph P. Hendrix, M.D.)

HERNANDO — Clinton J. McGrew Jr., M.D.

HIGHLANDS — Carlos J. Gonzalez, M.D.; (Absent — Luis M. Pena, M.D.)

HILLSBOROUGH — Richard A. Bagby, M.D.; Lewis H. Berger, M.D.; Frank C. Coleman, M.D.; Richard G. Connar, M.D.; Irving M. Essrig, M.D.; Richard S. Hodes, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Benedict S. Maniscalco, M.D.; Thomas E. McKell, M.D.; Robert E. McCammon, M.D.; Ralph E. Rydell, M.D.; Ronald L. Seeley, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D.; Mr. Roland Reeves, Student Delegate; (Absent — John C. Fletcher, M.D.)

INDIAN RIVER — Randall D. Bertolette, M.D.; James W. Large, M.D.; Paul W. Taylor, M.D.

LAKE — Joseph A. Comfort, M.D.; Joseph E. Holland, M.D.; Robert H. Hux, M.D.

LEE — Ronald D. Castellanos, M.D.; Larry P. Garrett, M.D.; Francis L. Howington, M.D.; H. Quillian Jones Jr., M.D.; Joseph P. O'Bryan, M.D.; Stephen R. Zellner, M.D.

MADISON — (Absent — Michael O. Stick, M.D.)

MANATEE — Thomas R. Busard, M.D; Julian Giraldo, M.D. Roger A. Meyer, M.D.; James T. Rogers Jr., M.D.; (Absent — William A. Boyce, M.D.)

MARION — Claude B. Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; Andrew F. Greene, M.D.; (Absent — George E. McLain, M.D.)

MONROE — Ronald H. Chase, M.D.

NASSAU — (Absent — Jose L. Castillo, M.D.)

OKALOOSA — David R. Arrowsmith, M.D.; Samuel M. Atkinson Jr., M.D.

ORANGE — Edward Ackerman, M.D.; Richard J. Bagby, M.D.; Clifford D. Bidwell, M.D.; Manuel J. Coto, M.D.; Clarence M. Gilbert, M.D.; Wayne L. Godbold, M.D.; David L. Mackey, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Wallace M. Philips Jr., M.D.; Charles T. Price, M.D.; James E. Richards Jr., M.D.; Robert N. Serros, M.D.; Cecil B. Wilson, M.D.; (Absent — Calvin R. Peters, M.D.)

OSCEOLA — Gilberto Perez, M.D.; (Absent — Robert E. McMillen, M.D.)

PALM BEACH — Vernon B. Astler, M.D.: J.A. Baker, M.D. Robert Burger, M.D.; Richard C. Cavanagh, M.D.; McKinley Cheshire, M.D.; Richard A. Chidsey, M.D.; Ralph R. Eastridge, M.D.; Lee A. Fischer, M.D.; James R. Forlaw, M.D.; James M. Johnson, M.D.; Myron M. Persoff, M.D.; William J. Romanos Jr., M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D.; H. Peter Wintrich, M.D.; (Absent — John D. Corbitt Jr., M.D.; V.A. Marks, M.D.)

PANHANDLE — Herbert E. Brooks, M.D.

PASCO — Ross G. Olson, M.D.; Herman R. Reno, M.D.; (Absent — Harvey O. Kaiser, M.D.)

PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert E. Dawson, M.D.; Charles K. Donegan, M.D.; John Flint, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris J. LeVine, M.D.; Jack A. MaCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; Howard L. Reese, M.D.; William H. Schmid, M.D.; Walter H. Winchester, M.D.; (Absent — John M. Hamilton, M.D.; David T. Overbey, M.D.; Bruce B. Smith, M.D.)

POLK — Ronald W. Case, M.D.; John W. Glotfelty, M.D.; Wiley E. Koon, M.D.; John C. Moore, M.D.; Robert B. Peddy, M.D.; David Stoler, M.D.; (Absent — Thomas M. Caswall, M.D.; Saul B. Gerber, M.D.)

PUTNAM — Roy E. Campbell, M.D.

ST. LUCIE-OKEECHOBEE — Charles R. Cambron, M.D.; William H. Meyer Jr., M.D.; (Absent — David L. Fromang, M.D.)

SANTA ROSA — David B. Young, M.D.

SARASOTA — John N. Carlson, M.D.; Samuel E. Kaplan, M.D.; Kenneth C. Kiehl, M.D.; Douglas R. Murphy, M.D.; Franklin H. Pfeiffenberger, M.D.; Richard C. Rehmeyer, M.D.; Karl R. Rolls, M.D.; David L. Thomas, M.D.

SEMINOLE — Orlando Garcia-Piedra, M.D.; Luis M. Perez, M.D.; Maria P. Perez, M.D.

SUWANNEE-HAMILTON-LAFAYETTE — (Absent - Philip L. Carey, M.D.)

TAYLOR — John H. Parker, M.D.

VOLUSIA — Martin S. Feigenbaum, M.D.; Robert W. Lankford, M.D.; Roger K. Lewis, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Charles A. Stump, M.D.

WALTON — (Absent — Howard F. Currie, M.D.)

WASHINGTON — (Absent — Muhammad Amin, M.D.)

SPEAKER OF HOUSE — James B. Perry, M.D.

VICE SPEAKER — Franklin B. McKechnie, M.D.

Dr. Perry requested that Dr. Dockery announce the winners of the FMA Golf Tournament. First Place Low Gross with a 76 was Dr. James G. White; Second Low Gross at 81 was Dr. Samuel L. Vinci; Third Low Gross at 81 was Dr. Charles Stump; and Fourth Low Gross at 91 was Dr. William W. Atkinson. In the Low Net Division, First Place went to Dr. Curtis D. Benton with a 69; Second Low Net at 65 was Dr. Samuel L. Vinci; Third Low Net at 66 was Dr. Michael Zamore; and Fourth Low Net at 61 was Dr. William W. Atkinson.

Dr. Dockery also announced the top three winners of the 1984 Health Run. In First Place with a running time of 17:17.9 was Dr. Chris Chappel; Second Place with a running time of 18:27.9 was Dr. C. Fenner McConnell; and Third Place with a running time of 18:43.9 was Mr. John Strange.

Dr. Dockery then asked Mrs. Mary Parham to come to the podium to introduce her husband and Executive Vice President of the Florida Medical Association, Dr. W. Harold Parham, to present his closing remarks upon his retirement from the Florida Medical Association.



Eugene G. Peek Jr., M.D., Ocala (left), and Will Parham escort Mrs. W. Harold (Mary) Parham to the podium to introduce Executive Vice President W. Harold Parham, D.H.A., as he addresses the House of Delegates for the final time.

Remarks — W. Harold Parham, D.H.A.
FMA Executive Vice President

Thank you, Mr. Speaker, for extending the Privilege of the Floor to me for a brief presentation. My services to the FMA in an official capacity terminate today; however, I will still be associated with you as Attorney-in-Fact and President of your Reciprocal and Chairman of the Board of PIMCO.

To each member of the FMA I wish to say thank you for the privilege and opportunity of working for you and with you for the past 35 years. You have provided me with a unique apprenticeship, for it has truly been a learning experience, and you obtained a Doctorate Degree for me as a bonus — the only time the University of Florida has ever held a convocation off campus — one of the highlights of my life! You have extended to me and my family every courtesy possible — professional, social, and personal. You have provided me the financial security to raise and educate my children and properly care for those who have needed me. You have given me the freedom to represent you in an aggressive, positive manner in the political arena, business world, with the news media, and wherever indicated. You have allowed me to actively participate in the formation and management of your Political Action Group (1950); your Foundation (1956); your Insurance Trust (1963); your Insurance Agency (1973); and your Insurance Reciprocal (1975).

In return I have attempted to always represent your points of view and your ideals and to adhere strictly to all your policies. In doing so, I have never found it necessary to apologize for the medical profession and to the best of my knowledge I have never given your adversaries a basis for criticizing you.

I am most grateful to each of you and particularly to those who, with your wives, have through the years taken me into your homes, made me feel like a member of your family and shared with me your concerns, anxieties, ambitions, hopes and accomplishments. Again, thank you, and may God bless each of you, your loved ones, and the organization that means so much to all of us.

Dr. Parham also recognized FMA staff that has served under him for the past several years, particularly Donald C. Jones, John E. Thrasher and Donald S. (Scotty) Fraser, and expressed his gratitude to all for their support and assistance throughout the years.



Mr. Jack Fortes, Director of Special Gifts, Stetson University, presents W. Harold Parham, D.H.A. the Distinguished Alumni Award.

Dr. Perry then invited Mr. Jack Fortes, Director for Special Gifts, of Stetson University to come to the podium for a special presentation to Dr. Parham. Mr. Fortes advised the House that Stetson University recent chose to honor Dr. Parham, an alumnus of Stetson University, with the coveted Distinguished Alumni Award at its homecoming celebration in February and wished to formally present the award to Dr. Parham at this time.

The Speaker then requested that the members of Reference Committee I come to the podium to present their report.

Report of Reference Committee No. I Health and Education

Dr. Perry called the Chairman and members of Reference Committee I, Health and Education, to present their report.

Dr. John M. Canakaris, Chairman, and his Committee came forward to present the report of Reference Committee No. I, Health and Education.

Report A of the Board of Governors

A motion of the Reference Committee that Recommendation No. A-1 be adopted as amended carried.

Recommendation No. A-2 was adopted as presented.

Report A of the Board of Governors was adopted as amended.

Report A of the Board of Governors

J. Lee Dockery, M.D., Chairman

Board Actions of Major Importance

FMA Councils and Committees

COUNCIL ON SCIENTIFIC ACTIVITIES

1984 Annual Meeting: The Board established the format for the 1984 Annual Meeting and approved a scientific theme, "The Health of the Public." FMA members can earn up to 20 hours of continuing medical education credit during four days of scientific programs which will include 33 scientific sections sponsored by FMA-recognized specialty groups in conjunction with the FMA Committee on Continuing Medical Education.

Accreditation Manual/CME Booklet: The Board approved publication of an accreditation manual which addresses the requirements of the ACCME *Essentials* and also the publication of a booklet for FMA members which outlines requirements and procedures relative to the FMA's mandatory program of continuing medical education.

Continuing Medical Education: The Board reaffirmed the philosophy of mandatory continuing medical education established by the FMA House of Delegates in May 1972 and directed that a letter be sent to all FMA members who have not verified the CME requirements in their most recent reporting cycle and that each member be advised as to the requirements of the program.

Foreign Medical Graduates: It is recognized that medical schools of the highest calibre and reputation exist in foreign countries throughout the world and their graduates historically have contributed significantly to the field of medicine. However, particularly in recent years, foreign medical schools have proliferated which offer little or no clinical training and provide educational experiences which fail to prepare their graduates adequately for the practice of medicine. Many of these schools are geographically located near Florida and, therefore, the influx of these graduates has a major impact on the health care system of the state. When a graduate applies for licensure examination to the Board of Medical Examiners, there is no mechanism to evaluate his educational program other than through curriculum transcripts which cannot possibly verify the quality of instruction. A major problem remains in the inability to adequately determine the educational quality of foreign medical school programs without an actual on-site visit.

In view of the gravity and magnitude of the entire problem of foreign medical school graduates, the Council on Scientific Activities would suggest to the FMA President that he consider appointing a special committee of the Board of Governors to work with the Council on Legislation, the Florida State Board of Medical Examiners, Federation of State Medical Boards, Liaison Committee on Medical Education, and other organizations involved, in order to thoroughly evaluate this multifaceted problem and to make and execute recommendations on a continuous basis.

RECOMMENDATION NO. A-1

THAT THE HOUSE OF DELEGATES APPROVE THE CONCEPT OF THE NEED FOR IMPROVED QUALITY CONTROL OVER LICENSURE OF FOREIGN MEDICAL GRADUATES AND THEIR ABILITY TO SIT FOR LICENSURE EXAMINATION IN FLORIDA AND RECOMMENDS TO THE STATE BOARD OF MEDICAL EXAMINERS THAT A JOINT COMMITTEE, COMPOSED OF MEMBERS FROM SBME AND FMA, BE ESTABLISHED TO ASSIST THE SBME IN IMPROVING QUALITY CONTROL OVER LICENSURE OF FOREIGN MEDICAL GRADUATES.



Reference Committee I (Health and Education) was chaired by John M. Canakaris, M.D., Bunnell. Left to right: Joseph Harris, M.D., Miami Beach; Rex Orr, M.D., St. Petersburg; Ms. Dawn Bouchard, Recorder; Dr. Canakaris; Alvin E. Smith, M.D., Ormond Beach; Jack W. MacDonald, M.D., Tallahassee; and Stephen R. Zellner, M.D., Ft. Myers.

FMA Journal: The Board expressed commendations to the Committee on Scientific Publications for the continuing excellence of *The Journal of the Florida Medical Association, Inc.*

The Board enthusiastically approved the President-Elect's nomination of Daniel B. Nunn, M.D., of Jacksonville, for reappointment as Editor of *The Journal of the Florida Medical Association, Inc.*, for 1984-85.

Specialty Society Participating Requirements: The Board approved the recommendation that the Board of Governors deny the use of scientific or educational exhibits as a method to satisfy participation requirements of specialty societies at Annual Meetings.

COUNCIL ON SPECIALTY MEDICINE

Specialty Society Legislative Programs: The Board reviewed recommendations from FMA-recognized specialty groups regarding FMA support for specialty society legislative objectives and referred these to the Council on Legislation for consideration in developing the FMA's legislative priorities for 1984.

Community Hospital Education Act: The Board expressed support for maintaining the Community Hospital Education Act without changes in the law or reductions in funding.

Blood Donor System: The Board expressed opposition to changes in the current blood donor system currently being used by blood banks that would allow designation of specific persons to receive donated blood.

Insanity Plea: The Board received the American Psychiatric Association's statement on the insanity defense (included as Appendix 1 to Report A of the Board of Governors in the *Delegates' Handbook)* and referred it to the Council on Legislation for appropriate action. The APA is making an effort to change the commitment standards and establish different release standards for persons who have been acquitted for crimes by reason of insanity.

Ineffective Drug List: The Board requested the AMA Diagnostic and Therapeutic Technology Assessment Department (DATTA) to review the list of drugs banned for Medicare/Medicaid payment to determine whether the drugs should be categorized as ineffective.

Respiratory Therapists: The Board endorsed credentialing through the certification process for respiratory therapists and expressed opposition to any type of licensure.

Radiologic Technologists: The Board endorsed legislation to encourage a more stringent examination for advanced level radiologic technologists with continuation of the two categories for certification.

Specialty Group Recognition: The Board approved continuing recognition for the following specialty groups who have met the criteria established by the FMA House of Delegates:

Florida Society of Colon and Rectal Surgeons
Florida Chapter, American College of Emergency Physicians
Florida Academy of Family Physicians
Florida Society of Internal Medicine
Florida Society of Nephrology
Florida Neurosurgical Society
Florida Obstetric and Gynecologic Society
Florida Society of Ophthalmology
Florida Society of Otolaryngology/Head and Neck Surgery
Florida Association of Pediatric Cardiologists
Florida Association of Pediatric Surgeons
Florida Society for Preventive Medicine
Florida Radiological Society, Inc.
Florida Chapter of American College of Surgeons
Florida Thoracic Society
Florida State Surgical Division, International College of Surgeons

Anabolic Hormone Bill: The Board approved in principle FMA support for legislation to oppose the Anabolic Hormone Bill. This bill will prohibit physicians from prescribing and supplying hormone drugs except under certain conditions.

Medical Doctor Inventory Form: The Board approved the addition of a medical doctor inventory form to the Medicare form in order for the Health Manpower Task Force to obtain needed information. Kerry E. Kilpatrick, Ph.D., of the Task Force, has asked for the Florida Medical Association's support in encouraging physicians to complete this form. The Council enthusiastically recommended that physicians participate in the completion of the 1983-84 Medical Doctor Inventory Form (included as Appendix 2 to Report A of the Board of Governors in the *Delegates' Handbook*.)

RECOMMENDATION NO. A-2

THAT THE HOUSE OF DELEGATES ENDORSE THE PRINCIPLE OF PHYSICIAN COMPLIANCE WITH THE 1983-84 MEDICAL DOCTOR INVENTORY FORM.

Blue Cross and Blue Shield PARS Plus Program: The Board received a report on the PARS Plus Program sponsored by Blue Cross and Blue Shield of Florida, Inc., and directed that a careful study of the components of the Program be conducted in order that an appropriate FMA position can be developed as warranted.

Report G
Supplement to Report A
of the
Board of Governors

Report G, Supplement to Report A, of the Board of Governors was adopted.

Report G
Supplement to Report A
of the
Board of Governors
J. Lee Dockery, M.D., Chairman

Specialty Group Recognition: In submitting recommendations to the Board of Governors at its meeting in March regarding continuing recognition for specialty groups, the Council deferred recommending continuing recognition for the Florida Region, American College of Physicians pending documentation that the society met the criteria for recognition. The society has subsequently demonstrated its compliance with the criteria for the continuing recognition program.

RECOMMENDATION NO. G-1

THAT CONTINUING RECOGNITION BE GRANTED BY THE FLORIDA MEDICAL ASSOCIATION TO THE FLORIDA REGION, AMERICAN COLLEGE OF PHYSICIANS AS AN APPROVED SPECIALTY GROUP HAVING MET THE CRITERIA ESTABLISHED BY THE HOUSE OF DELEGATES.

Report of the
Council on Scientific Activities

The Reference Committee wished to recognize the outstanding contributions to the members of the Florida Medical Association by Daniel B. Nunn, M.D., Editor, *The Journal of the Florida Medical Association, Inc.*, for his excellent publication which provides an on-going forum for communication of medical issues and scientific literature.

The Report of the Council on Scientific Activities was adopted.

Council on Scientific Activities
Henry M. Yonge, M.D., Chairman

The Council on Scientific Activities has had an extremely active year meeting four times in conjunction with meetings of component committees and subcommittees. Council and committee business began on May 5, 1983, in Hollywood, with preliminary plans for the 110th Annual Meeting at Lake Buena Vista. Subsequent meetings were held on August 5, 1983 in Jacksonville, September 30, 1983 in Lake Buena Vista, and February 10, 1984 in Tampa. The Council's work is summarized under the heading of each committee and subcommittee.

Committee on Medical Education

Calvin W. Martin, M.D., Arcadia, has completed another highly successful year as Chairman of this Committee. Major activities of the Committee this year have focused on the 110th Annual Meeting Scientific Program, ACCME accreditation of hospital continuing medical education programs, approval of Florida Medical Association mandatory credit for CME providers, and the issue of foreign medical school graduates.

Subcommittee on Annual Meeting Scientific Program

Under the continued leadership of Orris O. Rollie, M.D., Orlando, the Subcommittee has again produced an outstanding scientific program for the 110th Annual Meeting in collaboration with FMA recognized specialty groups. A highlight of the scientific program will be the FMA sponsored symposium, "The Health of the Public", to be held Friday, May 4, 1984. Featured speakers will be Edward N. Brandt, M.D., Assistant Secretary, Department of Health and Human Services (HHS), and James Mason, M.D., Director, Center for Disease Control. Additional attractions will include sections on chemical dependency, malpractice prevention, Wyeth Programmed AutoTutors, Pfizer "Dialogue" Programs, and many technical, scientific and educational exhibits.

Once again, the Annual Meeting Scientific Program will offer a total of twenty hours of AMA Category I approved continuing medical education credit. Additional co-sponsorship by the Colleges of Medicine of the University of Florida, University of Miami, and University of South Florida will be included.

For the first time this year, the FMA Leadership Conference offered a scientific program on Friday afternoon. Four topics were presented by outstanding speakers and one hundred percent of the evaluation comments favored offering a scientific program at each Leadership Conference.

Subcommittee on Accreditation

Samuel E. Crockett, M.D., Orlando, has continued his effective leadership as Chairman of this Subcommittee. The *ACCME Essentials* became effective on January 1, 1984, and there has been brisk activity in the area of program accreditation. The following actions have been taken since the last Annual Meeting:

— **University Community Hospital,** Tampa — Accredited for a two-year period, April 8, 1983 to April 7, 1985.
— **Good Samaritan Hospital,** West Palm Beach — Accredited for a one-year period, January 27, 1983 to January 26, 1984.
— **Mercy Hospital,** Miami — Reaccredited for a three-year period, May 18, 1983 to May 17, 1986.
— **American Hospital,** Miami — Reaccredited for a one-year probationary period, September 24, 1983 to September 23, 1984.
— **Winter Haven Hospital,** Winter Haven — Reaccredited for a three-year period, October 13, 1983 to October 12, 1986.

Subcommittee on Program Approval

Chairman David S. Hubbell, M.D., St. Petersburg, and his Subcommittee have continued to provide outstanding service to CME providers in Florida who have sought FMA mandatory credit for their programs. After programs are reviewed and approved by county medical society CME chairmen, various members of the Subcommittee evaluate applications and award credit if approved. In 1983, over 1,200 hours of FMA mandatory credit were awarded in 452 separate programs.

Committee on Scientific Publications

Daniel B. Nunn, M.D., is completing his fourth successful year as Editor of *The Journal of the Florida Medical Association, Inc.*, and Chairman of the Committee on Scientific Publications. Moreover, Dr. Nunn has been reappointed to serve for a fifth year, which is the maximum tenure allowed by the Board of Governors. Since submitting the previous annual report of the Council, *The Journal of the Florida Medical Association, Inc.*, received first place in the State Medical Journal Category of the Sandoz Pharmaceutical Annual Medical Journalism Awards Contest.

Special Issues

Special issues continue to be an exciting and valuable addition to regular monthly issues of *The Journal*. Since last May, another outstanding historical issue was produced by Guest Editor, William M. Straight, M.D.; a special issue on Perinatology was printed in September coordinated by Guest Editor Lewis A. Barness, M.D.; and November included a special issue on Computers in Medicine with Guest Editors, Lamar Crevasse, M.D., and Mario Ariet, Ph.D. April promises a special issue on Substance Abuse co-sponsored by the FMA Committee on Substance Abuse and the FMA Auxiliary. At least one additional special issue is planned in 1984 with a special issue on "The Health of the Public" sponsored by the FMA Committee on Public Health.

Report of the Council on Specialty Medicine

The motion of the Reference Committee that the report of the Council on Specialty Medicine be adopted as printed in the Handbook carried.

Council on Specialty Medicine
D. Orvin Jenkins, M.D., Chairman

The Council on Specialty Medicine held three meetings during the Association year 1983-84: August 28, 1983; December 11, 1983; and February 12, 1984. The Subcommittee on Recognition for Specialty Groups held meetings in conjunction with all three Council meetings. A special meeting was held with hospital-based physicians who are representatives to the Council on Specialty Medicine for the purpose of discussing some of the problems these physicians are encountering. The Council recommended that the Florida Medical Association membership at large offer their assistance to hospital-based physicians, if warranted.

The Council is comprised of 38 FMA recognized specialty groups representing all major areas of medical practice. Many different issues were considered by the Council during the Association year. Major issues reviewed by the Council included:

1. **Florida Orthopedic Society:** The Council recommended that the FMA approve the recommended legislative objectives as submitted by the Florida Orthopedic Society and that they be included in the 1983-84 program of the Florida Medical Association.
2. **Florida Society of Ophthalmology:** The Council recommended that the FMA approve the recommended legislative objectives submitted by the Florida Society of Ophthalmology and that they be included in the 1983-84 program of the Florida Medical Association.
3. **Community Hospital Education Act:** The Council recommended that the FMA support the Florida Academy of Family Physicians' proposal to maintain the Community Hospital Education Act without changes in the law or in the funding format. This recommendation was proposed in order for studies to be conducted regarding the need for changes in graduate training programs for primary care physicians.
4. **Florida Society of Pathologists:** The Council recommended that the FMA support the legislative objectives as submitted by the Florida Society of Pathologists and include opposing changes in the current Blood Donors System that would allow designation of special persons to receive donated blood and that these objectives be included in the 1983-84 legislative program.
5. **Liaison Committee to the Florida Physicians' Insurance Reciprocal:** The Council submitted to the Board nominations of physicians for appointment to the Liaison Committee to the Florida Physicians' Reciprocal. The Committee has met twice during the Association year. The purpose of this Committee is to improve the relationship between the Florida Physicians' Insurance Reciprocal and the FMA membership.
6. **Council of Florida District Branches, American Psychiatric Association:** The Council recommended that the American Psychiatric Association's statement on the insanity defense be referred to the Council on Legislation for appropriate action. The APA is making an effort to change the commitment standards and establish release standards for persons who have been acquitted for crimes by reason of insanity.
7. **Specialty Society Relations:** The Council approved the following recommendations of a study group established by the FMA Board of Governors to address the relationship of FMA recognized specialty groups to the Council on Specialty Medicine.

    1. That the criteria for appointment to the Council and its functions remain unchanged.
    2. That a recommendation be submitted to the House of Delegates that the FMA Bylaws be amended to provide that each FMA recognized specialty group be allowed one vote in the House of Delegates.

3. That the FMA approve, in principle, to offer to provide administrative services to recognized specialty groups through letter agreement on a cost reimbursement basis and requested that a proposal be submitted to the Executive Committee at its next meeting as to how this function might best be implemented.

8. **Respiratory Therapists:** The Council recommended that the FMA endorse credentialing of respiratory therapists and oppose any type of licensure.
9. **Anabolic Hormone Bill:** The Council recommended that the FMA oppose the Anabolic Hormone Bill.
10. **Radiologic Technologists:** The Council recommended that the FMA support legislation for a more comprehensive and stringent exam for radiologic technologists and continuation of the "full" and "limited" categories of technician certification.
11. **Pharmacy Consultant Bill:** The Council recommended that the FMA strongly oppose, with all available resources, the Pharmacy Consultant Bill.
12. **Medicaid Reimbursement:** The Council recommended that the FMA encourage the Department of Health and Rehabilitative Services to increase the rate of compensation for physicians who treat Medicaid patients.
13. **Assignment of Benefits:** Resolution 83-6 "Assignment of Benefits" was reviewed by the Council. Major health insurance companies in the state were surveyed to determine the policy of the individual companies regarding assignment of benefits. FMA Legal Counsel was requested to investigate the legality of insurance companies who do not honor assignment of benefits on insurance forms. Legal Counsel reviewed the existing Florida Statutes and determined that it was legal for the insured to revoke assignments of benefits provided the insurance company was notified prior to making payment. The Chairman of the Council on Medical Economics, Charles P. Hayes Jr., M.D., met with the Council on Specialty Medicine to discuss problems pertaining to the assignment of benefits. The Council on Medical Economics meets regularly with the medical directors of health insurance companies in the state to discuss various medical economic issues and has discussed the issue of assignment of benefits. As a result, the Council on Specialty Medicine recommended that the specialty societies cite specific instances of failure to pay claims by insurance companies and report these incidents to the Council on Medical Economics for further action.

    The Council also recommended that the FMA encourage the health insurance companies to develop a policy of notifying physicians when a claim is revoked.
14. **Specialty Group Recognition:** The Council approved continuing recognition for the following specialty groups who have met the criteria established by the FMA House of Delegates:

    Florida Allergy and Immunology Society
    Florida Chapter, American College of Chest Physicians
    Florida Society of Colon and Rectal Surgeons
    Florida Chapter, American College of Emergency Physicians
    Florida Academy of Family Physicians
    Florida Society of Internal Medicine
    Florida Society of Nephrology
    Florida Neurosurgical Society
    Florida Obstetric and Gynecologic Society
    Florida Society of Ophthalmology
    Florida Society of Otolaryngology/Head and Neck Surgery
    Florida Association of Pediatric Cardiologists
    Florida Association of Pediatric Surgeons
    Florida Society for Preventive Medicine
    Florida Radiological Society, Inc.
    Florida Chapter, American College of Surgeons
    Florida Thoracic Society
    Florida State Surgical Division, International College of Surgeons

Many other issues were discussed and considered by the Council. Most of these were informational items.

Report of the Florida Medical Foundation

Medical Student Loans

The item in the Florida Medical Foundation Report regarding Medical Student Loans was adopted as amended. (See the Florida Medical Foundation Report, page 596.)

The Chairman expressed his appreciation to all members of the Association who provided guidance and counsel. Special thanks were conveyed to Richard G. Connar, M.D. and William B. Deal, M.D., who represented the AMA Delegates at the meeting of the Reference Committee. Dr. Canakaris also expressed his sincere appreciation to the members of the Committee, Stephen R. Zellner, M.D.; Alvin E. Smith, M.D.; Joseph Harris, M.D.; Rex Orr, M.D.; and Jack W. MacDonald, M.D. The Reference Committee also thanked the FMA staff, Dr. Robert C. Fore and Ms. Dawn Bouchard for their assistance in the preparation of the report.

The motion of the Reference Committee that the report of Reference Committee No. I, Health and Education, be adopted as amended carried.

Report of Reference Committee No. II Public Policy

Dr. Perry called the Chairman and members of Reference Committee No. II, Public Policy, to present their report.

Dr. Margaret C.S. Skinner, Chairman, and her Committee came forward to present the report of Reference Committee No. II, Public Policy.

Report B
of the
Board of Governors

The Reference Committee commended the Board of Governors for its outstanding performance during the year.

Prescription Abuse Data Synthesis (PADS) — The Reference Committee noted they were made aware of the numerous shortfalls of the computer reports as generated by the current data base utilized in the PADS project, and further that the manner in which the FMA became aware of the project was less than optimal. For these reasons and because of the need to closely monitor this project, the Reference Committee recommended that the Proposed FMA Policy on Drug Diversion, Identification and Intervention be amended.

The Reference Committee moved an amendment to the Proposed FMA Policy on Drug Diversion, Identification and Intervention (PADS) for clarification in the wording of point "4" under "Definition" and point "2-B" under "Management" to read ". . .Dated or Undereducated Doctors/Medical Professionals;" and amend the wording in item "C" under point "2" to read "The professional will be allowed to enroll into a drug treatment program approved by the professional society."

The amendment carried and the FMA Proposed Policy on Drug Diversion Identification and Intervention (PADS) was adopted as amended.

Recommendation No. B-1 was adopted as presented.

A motion of the Reference Committee carried that the FMA Board of Governors be directed to designate and charge appropriate committees of the FMA to closely monitor the proceedings of the PADS project.

In discussions relevant to Recommendation No. B-1, the Reference Committee expressed concern regarding an item in the Medical Practice Act pertaining to Schedule II drugs (Chapter 458.331, Item 1, Section 2, Page 197, Subsections BB, CC 1-3). Schedule II drugs include many of the analgesics and narcotics in common therapeutic usage, as well as



Reference Committee II (Public Policy) was chaired by Margaret C. S. Skinner, M.D., Miami. Left to right: James T. Cook III, M.D., Panama City; Kenneth C. Kiehl, M.D., Sarasota; Wallace M. Philips Jr., M.D., Orlando; Dr. Skinner; Ms. Jacki Snider, Recorder; Joseph T. Ostroski, M.D., Alternate, Miami; Mark V. Barrow, M.D., Alternate, Gainesville; and Thomas R. Civitella, M.D., Port Charlotte.

amphetamines and sympathicominetic substances. The Reference Committee was concerned that the current wording of the listed sections could be construed to mean that prescription of any substance in Schedule II could be considered illegal. A motion of the Reference Committee carried that clarification of the Medical Practice Act regarding the prescribing of substances in Schedule II be referred to the Board of Governors for appropriate action.

A motion of the Reference Committee was carried to amend the item relating to measles immunization by deleting the word "Measles" in the caption and substituting the words "Rubella and Rubeola," and by amending the last two lines to read ". . .that proof of immunity to rubella and rubeola be a recommendation for entrance to all colleges in Florida, and further that individual consideration be given to non-immune older applicants for whom immunization might be contraindicated."

The Reference Committee noted that it had heard a great deal of testimony regarding the Florida High School Activities Form, which is similar to that developed by the Florida Heart Association, and was considered in Reference Committee II in 1983, and which has been widely distributed to school systems, county medical societies and other specialty associations. In view of the confusion as to the most appropriate and widely promulgated form, and in spite of the obvious delay in the final form selection, the motion of the Reference Committee to refer this matter back to the Board of Governors carried.

A motion of the Reference Committee carried to refer Recommendation No. B-2 back to the Board of Governors.

A motion of the Reference Committee carried to refer Recommendation No. B-3 back to the Board of Governors.



President J. Lee Dockery, M.D., and Council on Scientific Activities Chairman Henry M. Yonge, M.D.

The Reference Committee heard testimony that synthetic heroin can be detected in drug screening laboratory examinations and for that reason the motion by the Reference Committee was carried to refer back to the Board of Governors for clarification and verification the memorandum on synthetic heroin.

Report B of the Board of Governors was adopted as amended.

Report B
of the
Board of Governors
J. Lee Dockery, M.D., Chairman

FMA Councils and Committees

COUNCIL ON MEDICAL SERVICES

Prescription Abuse Data Synthesis (PADS): The Board authorized the FMA to actively participate in the PADS project and assist the state of Florida in the development of an intervention policy designed to identify and assist non-criminally involved physicians such as the impaired physician, the dated physician and the duped physician as described in the PADS model. The Board also authorized the FMA Committee on Substance Abuse and the Impaired Physicians Committee to recommend policy on intervention to the PADS project.

The Board reviewed the proposed FMA policy statement on drug diversion, identification and intervention (included as Appendix 1 to Report B of the Board of Governors in the *Delegates' Handbook).*

RECOMMENDATION NO. B-1

THAT THE HOUSE OF DELEGATES ADOPT THE PROPOSED POLICY STATEMENT ON PRESCRIPTION ABUSE DATA SYNTHESIS (PADS) TO BE SUBMITTED TO THE STATE PADS PROJECT.

Methodone Treatment: The Board recommended to the Secretary of the Department of Health and Rehabilitative Services that he consider, in consultation with the FMA, the appointment of a committee to review and make recommendations regarding existing state Methodone regulations especially as they pertain to licensing and operating a Methodone program.

"Opium" Perfume: The Board requested Florida's Delegates to the AMA to submit a resolution at the 1983 Interim Meeting of the AMA House of Delegates which expresses great concern over the highly promotional advertising campaigns being conducted by the manufacturers of certain perfumes and colognes directed at young people which implies that illicit drug experience is exciting and desirable. The resolution was adopted:

RESOLVED, That the AMA notify the management of E. R. Squibb & Sons, Inc. Pharmaceuticals of its strong objection to the advertising campaign on "Opium" perfume; and therefore be it further

RESOLVED, That the AMA express strong objection to the management of Pippo, Inc., of the "Stash" advertising campaign, House of Dinard, Inc., of the "Sinsemalla" advertising campaign and Cocaine International of the "Cocaine" advertising campaign.

(Also see AMA Delegates Annual Report in the *Delegates' Handbook)*

Cardiopulmonary Resuscitation: The Board recommended to the Department of Education that it implement as part of the public school system curriculum a cardiopulmonary resuscitation course.

Rubella and Rubeola Immunization: The Board recommended to the Department of Health and Rehabilitative Services, the Department of Education and the Council on Post-Secondary Education that proof of immunity of Rubella and Rubeola be a recommendation for entrance to all colleges in Florida, and further that individual consideration be given to non-immune older applicants for whom immunization might be contraindicated.

Public Safety: The Board requested that the FMA President and others as deemed appropriate consult with the Secretary of the Department of Health and Rehabilitative Services regarding the FMA's concern regarding state laboratory charges for cultures for gonorrhea, tuberculosis and other communicable diseases and that there should be no charge for these tests as they are part of the state's public health responsibility in monitoring and controlling communicable diseases.

Environmental Personnel: The Board recommended to the Secretary of the Department of HRS the need to recruit and train environmental protection personnel including medical professionals to ensure environmental issues are properly handled.

Florida High School Activities Form: The Board considered the Council's proposal for developing a Florida high school activities form to consolidate into one standard form the number of pre-participation athletic forms presently being utilized in the state (included as Appendix 2 to Report B of the Board of Governors in the *Delegates' Handbook.)*

RECOMMENDATION NO. B-2

(Not adopted — Referred to the Board of Governors)

THAT THE HOUSE OF DELEGATES ENDORSE THE FLORIDA HIGH SCHOOL ACTIVITIES FORM AND RECOMMEND TO THE FLORIDA HIGH SCHOOL ACTIVITIES ASSOCIATION THAT IT BE USED THROUGHOUT THE STATE OF FLORIDA WITH URINALYSIS AND HEMATOCRIT TESTING BEING OPTIONAL.

RECOMMENDATION NO. B-3

(Not adopted — Referred to the Board of Governors)

THAT THE HOUSE OF DELEGATES RECOMMEND TO THE FLORIDA HIGH SCHOOL ACTIVITIES ASSOCIATION THAT PRE-PARTICIPATION PHYSICALS BE REQUIRED ONCE AT THE ENTRY OF JUNIOR HIGH SCHOOL LEVEL AND ONCE AT THE ENTRY OF HIGH SCHOOL LEVEL WITH ANNUAL UPDATED HISTORIES ON A YEARLY BASIS.

Pediatric Emergency/Critical Care/Trauma Network: The Board reaffirmed the concept endorsed by the Florida Medical Foundation Emergency Medical Services Project for establishing a pediatric emergency/critical care/trauma network within the Children's Medical Services (CMS) programs of the Department of Health and Rehabilitative Services.

The Board supported enactment of legislation establishing and identifying appropriate criteria for a CMS emergency medical/critical care/trauma/poison control program which will effectively interface with the ongoing, statewide, CMS Perinatal Intensive Care Program and will also ensure optimum utilization of other related CMS services, including the Neonatal Intensive Care Communication (Care-Line) Transport System and the CME Pilot Program for Poison Control.

Public Relations Program — Emergency Medical Services: The Board approved the development of an FMA educational public relations program that will illustrate the significant role of emergency medical services in Florida's health care system.

Public Relations Program — Senior Citizens: The Board reaffirmed the development of public education programs on support services that are available to citizens including promotion of the concept of family health care and that a pilot project be initiated for an educational campaign outlining home health care and other services available to the elderly.

EDB: The Board expressed commendations to the Secretary of the Department of HRS and the state health officer for their efforts in publicizing the problem of EDB residue in food and water, and for developing the policy that the health of the public must be protected by limiting exposure to this toxic chemical until further research determining safe and acceptable levels in food and water is established.

The Board also commended the Commissioner of Agriculture for his firm position on EDB under extremely difficult circumstances and for his complete cooperation with the Department of HRS in accepting recommendations that were submitted.

Health Education Curricula: The Board encouraged the Department of Education to incorporate health and fitness courses into the curricula for middle grades five through eight preferably through health and physical educational courses.

Synthetic Heroin: The Board approved of distribution to the FMA membership the synthetic heroin memorandum developed by the State of California Department of Alcohol and Drug Programs. This memorandum describes the types of synthetic heroin that are in existence and reactions of its consumption (included as Appendix 3 to Report B of the Board of Governors in the *Delegate's Handbook).* Referred back to the Board of Governors for clarification and verification.

FMA Scientific Program: The Board suggested to the Committee on Medical Education that it consider including subject matter regarding maternal and child health, AIDS, and environmental hazards as part of the FMA Annual Meeting Scientific Program, and further, that one of the key speakers be a prominent health officer.

Public Health Committee Assistance: The Board suggested to the Medical Education Committee that it utilize the Public Health Committee in developing the FMA Annual Meeting Scientific Program.



A proud first family poses for the Journal photographer. From left to right are Laura Katherine Dockery, President J. Lee Dockery, M.D., Michael Dockery, Mrs. J. Lee (Barbara) Dockery, and Kim Dockery.

Report of the Council on Medical Services

The motion of the Reference Committee that the report of the Council on Medical Services be adopted as printed in the Handbook carried.

Council on Medical Services
Roy M. Baker, M.D., Chairman

The Council on Medical Services held two meetings during the Association year 1983-84: September 29, 1983 in Jacksonville, and February 23, 1984 in Tampa. A Council telephone conference was conducted on December 29, 1983. Five of the Council's Committees deal with issues which impact virtually all citizens of Florida. Listed below is a summary of the year's activities of the Committees on Aging, Substance Abuse, School Health, Public Health and Emergency Medical Services.

Committee on Aging

The Committee on Aging, chaired by Donald G. Nikolaus, M.D., held two meetings and one telephone conference call addressing several subjects relating to the delivery and cost of health care to the elderly citizens of Florida. The Committee developed an outline for the public relations program on home health care for the elderly. This program is expected to be completed by the summer of 1984 and is to be presented to the various county medical societies.

The Committee also reviewed legislation pertaining to aging, issues relating to nursing home care and held a meeting with the various aging agencies in the state to learn about the multitude of services that are available to the elderly. The Committee also studied the curricula in the state's three medical schools that provide training in geriatric care.

Committee on Substance Abuse

The Committee on Substance Abuse, chaired by Donald I. Macdonald, M.D., held three meetings and one telephone conference call during the Association year. The Committee actively participated in the state Prescription Abuse Data Synthesis (PADS) Program and developed a policy on drug diversion, identification and intervention that was submitted to the PADS project. Several recommendations were made relating to the state methadone treatment centers and on how to improve the existing methadone regulations. The Committee developed the format for the special *Journal* issue on "Substance Abuse" and recommended that the FMA notify the management of SQUIBB of its disapproval of the Opium campaign. The Committee reviewed all legislation pertaining to substance abuse and reviewed the curricula pertaining to substance abuse in the state's three medical schools. Presently, the Committee is developing a curriculum to orient the newly graduated medical doctors about substance abuse.

Committee on School Health

The Committee on School Health, chaired by Bernard Kimmel, M.D., serves as an advisory Committee to the Department of Education and Health Program Office of the Department of Health and Rehabilitative Services. The Committee met twice during the Association year and made recommendations concerning training to administer epinephrine, pre-participation athletic physicals, including development of a pre-participation athletic physical form. In addition, the Committee reviewed legislation pertaining to health education and school health services.

The Committee made recommendations concerning emergency first aid procedures for insect stings, and the use of the Hollister-Steer emergency epinephrine kits for insect stings. Additional recommendations were made regarding health education in high school and physical examinations for school bus drivers.

Committee on Public Health

The Committee on Public Health, chaired by Patricia C. Cowdery, M.D., met twice during the Association year and considered a broad range of important subjects affecting public health that included maternal child care, immunization policies, care for the needy, and school entry physical examinations. The Committee made several recommendations on funding of county health departments, the employment of trained environmental personnel and public health education. The Committee is presently in the process of developing a special *Journal* issue on "The Health of the Public". The Committee also reviewed all subject material pertaining to the problem of EDB and other toxic chemical pollution. The Committee reviewed all legislation pertaining to public health.

Committee on Emergency Medical Services

The Committee on Emergency Medical Services, chaired by Joseph T. Ostroski, M.D., met twice and held a telephone conference call during the Association year. The Committee devoted a large portion of its time to the implementation of the FMF/State EMS Project. The Committee reviewed all legislation relating to trauma and initiated the development of a Critical Bed Inventory on the GTE Medical Information Network. The Committee is presently developing a public relations program on trauma to be presented to the citizens of Florida.

Florida Medical Foundation Emergency Medical Services Project

The item in the Florida Medical Foundation Report on the Emergency Medical Services Project was adopted. (See report of the Florida Medical Foundation on page 596.)

RESOLUTION 84-3 Therapeutic Substitution

Pinellas County Medical Society

Resolution 84-3 was adopted.

Whereas, Therapeutic substitution is the replacement of a prescribed medication by a drug that contains some or all chemically inequivalent ingredients of the same pharmacologic or therapeutic class that can be expected to have similar therapeutic effects; and

Whereas, Successful medical treatment is based upon carefully individualized diagnosis and treatment by a physician; and

Whereas, The pharmacist cannot know the detailed medical history and findings in each patient; and

Whereas, Therapeutic substitution may be dangerous to the patient in many situations; therefore be it

RESOLVED, That the Florida Medical Association assume an official position of opposition to therapeutic substitution of drugs by pharmacists unless the substitution is approved by the prescribing physician in each instance, and that the Florida Medical Association communicate this position to the Florida Department of Health and Rehabilitative Services, to the Florida Hospital Association and to the Joint Commission on Accreditation of Hospitals.

The Chairman expressed his appreciation on behalf of the Reference Committee to all members of the Association who provided guidance and counsel, and to Dr. Roy M. Baker, Chairman of the Council on Medical Services. Special thanks were conveyed to Robert E. Windom, M.D. and Joseph T. Ostroski, M.D. who represented the AMA Delegates at the meeting of the Reference Committee. Dr. Skinner also expressed her sincere appreciation to members of the Committee: James T. Cook III, M.D.; Kenneth C. Kiehl, M.D.; Wallace M. Phillips Jr., M.D.; Thomas R. Civitella, M.D.; and Mark V. Barrow, M.D. The Reference Committee also thanked the FMA staff, Mr. Edward D. Hagan; Mr. Donald W. Weidner, Esq.; and Miss Jacki Snider for their assistance in the preparation of the report.

The motion of the Reference Committee that the report of Reference Committee No. II, Public Policy, be adopted as amended carried.

Report of Reference Committee No. III Finance and Administration

Dr. Perry called the Chairman and members of Reference Committee No. III, Finance and Administration, to present their report.

Dr. Paul A. Flaten, Chairman, and his Committee came forward to present the report of Reference Committee No. III, Finance and Administration.

Remarks of the Speaker of the House

Dr. Flaten expressed his Committee's wish to commend Dr. Perry for the clear and precise rules under which the House of Delegates acts and for Dr. Perry's summary given at the beginning of the meeting.

The Remarks of the Speaker presented at the First House of Delegates were filed. (See page 537, First House of Delegates.)

President's Address

Dr. Flaten expressed his Committee's wish to commend Dr. Dockery for his outstanding leadership on behalf of the members of the Association for the past year.

The President's Address presented at the First Meeting of the House was filed. (See "President's Address," page 531.)

Report C of the Board of Governors

J. Lee Dockery, M.D., Chairman

The Reference Committee commended the Board for its outstanding performance during the year and suggested particular action on the recommendations as follows:

Recommendations No. C-1 and C-2 were adopted by the First Meeting of the House of Delegates and therefore were not considered by the Committee.

Recommendation No. C-3 was adopted as presented.

There was lengthy discussion from the floor of the House regarding the adoption of Recommendation No. C-4. Upon careful deliberation, Recommendation No. C-4 was referred to the Board of Governors.

Recommendation No. C-5 was adopted as presented.

A motion of the Reference Committee was carried to amend Recommendation No. C-6 by changing the word "approved" to "appointed" on line 6 of the recommendation. Recommendation No. C-6 was adopted as amended.

Recommendation No. C-7 was adopted as presented.

Recommendation No. C-8 was adopted as presented.

Recommendation No. C-9 was adopted as presented.

Report C of the Board of Governors was adopted as amended.

Report C of the Board of Governors

J. Lee Dockery, M.D., Chairman

On behalf of the Board of Governors, your Chairman is both proud and pleased to submit this report to the House of Delegates regarding the many activities of the Board of Governors and the Association's Councils and Committees during the past Association year.

Your Board and the many physicians who have given so much of their time and talents to the Florida Medical Association have done so to assure that the highest level of quality medical care remains available to our fellow Florida citizens and visitors. It is the quality of medical care that can only be preserved and delivered through our free enterprise system.

This report addresses the many issues that physicians face both individually and collectively and how your colleagues working through organized medicine at the national, state and local levels are attempting to do something about the complex and critical issues of our time. Special attention is called to the considerable amount of time and resources that have gone and continue to go towards eliminating the professional liability crisis that plagues our profession and our patients.

Your Chairman has been honored for having had the opportunity of working with the many dedicated physicians who have actively served during the past year on the Association's Councils and Committees. I would particularly like to thank those dedicated physicians with whom it has been my personal privilege and honor to serve on the Board of Governors. Each of your Board members have given freely of their time and talents and have kept the best interest of all physicians and the betterment of health care uppermost in their minds.

Frank C. Coleman, M.D., President-Elect
James G. White, M.D., Vice President
Luis M. Perez, M.D., Secretary
Yank D. Coble Jr., M.D., Treasurer
Robert E. Windom, M.D., Immediate Past President — 1985
James B. Perry, M.D., Speaker of the House
Sanford A. Mullen, M.D., Past President — 1984
Robert E. Boyett, M.D., At Large — 1984
Gerold L. Schiebler, M.D., District A — 1986
Kay K. Hanley, M.D., District B — 1987
Dick L. Van Eldik, M.D., District C — 1985
Norman M. Kenyon, M.D., District D — 1984
Charles K. Donegan, M.D., AMA Delegate — 1984
Eugene G. Peek Jr., M.D., HRS — 1984
Vernon B. Astler, M.D., FPIR — 1984
Robert N. Webster, M.D., SBME — 1984
Mr. D. Scott Featherman, Student Member, 1984

To my successor, Dr. Frank Coleman, I extend my best wishes and my optimistic belief that his year as President will be a deeply rewarding experience as mine has been. With the level of leadership in Florida medicine and the many dedicated physicians who give of their time and talents in behalf of their colleagues, he can only succeed.

Major Activities

1984 Annual Meeting Format: The Board established the format for the 1984 Annual Meeting which is scheduled to be held at the Buena Vista Palace Hotel in Lake Buena Vista, Florida, May 2-6, 1984 and approved as the scientific theme, "The Health of the Public".

FMA Leadership Conference: "Medicine at a Crossroad" was the theme for the FMA Leadership Conference held January 27-29, 1984 at the Sheraton at St. Johns Place in Jacksonville. The sessions attracted 389 physicians, spouses and guests to Jacksonville where the FMA was founded 110 years ago. Forty of the FMA's forty-six component county medical societies were represented.

Florida's medical leaders were urged to establish a cooperative relationship with the media, become active in politics, and knowledgeable about alternative health care delivery systems and new methods of payment.

Experts offered these and many other valuable points of guidance during workshops conducted in conjunction with the Leadership Conference. The large turnout was enhanced by a special Called Meeting of the FMA House of Delegates on Saturday, January 28. The session was called exclusively for determination of the course FMA will take this year toward resolving the professional liability crisis in Florida.

After the House adjourned on Saturday afternoon, two-hour workshops on Media Relations, Legislation and Medical Economics were conducted. They were repeated the following morning.

A broad range of issues affecting medicine were discussed including media relations, state and national legislative issues, prospective payment systems (DRGs), alternative health care delivery mechanisms, cost containment and peer review organizations.

In addition to the workshop sessions, AMA President-Elect Joseph F. Boyle, M.D., and AMA Executive Vice President James H. Sammons, M.D., addressed general sessions on Saturday and Sunday morning respectively.

As a business, Dr. Boyle pointed out that the health care industry is a tremendous success. It has grown over the past 10 years by 70 percent, employs 70 million people and serves 30 million clients a day. As the nation's second largest industry, it accounts for 10 percent of the gross national product.

"At the same time, we have become a major concern of government, business and industry, for health care is the largest cost of doing business for many corporations," he said.

"We have become a target because of the cost of providing care," he continued. "When cost becomes a principal concern, there will be dilution of access and quality of care."



Reference Committee III (Finance and Administration) was chaired by Paul A. Flaten, M.D., Ft. Lauderdale. Left to right: A. Frederick Schild, M.D., Miami; Douglas R. Murphy, M.D., Venice; Robert E. McCammon, M.D., Tampa; Ms. Kriss Hanley, Recorder; Dr. Flaten; Wilbur L. Dawkins, M.D., Jacksonville; and Richard J. Bagby, M.D., Winter Park.

With regard to prospective payment, Dr. Boyle said the U.S. House of Representatives has come "very, very close to a line, and if we are behind this line, we will forever surrender our rights and our patients' rights. . ."

Dr. Sammons advised medical leaders not to listen to those who say that nothing is going to happen to medicine in the Washington arena this year because 1984 is an election year.

"Everyone says nothing is going to happen in 1984," Dr. Sammons said. "That's nonsense! We have some real potential problems in 1984. We're the last plum they have ready to be plucked."

He listed DRGs for doctors, fee limits and mandatory assignments as some of the important issues affecting medicine this year.

Some of the current problems with allied health professions have been enhanced by the actions of physicians themselves, he said.

"We have nurse midwives because doctors quit delivering babies," he said. "Doctors have quit seeing patients after 5:00 p.m. and send them to the emergency room, where the costs are much higher.

"Nurse midwives, opticians and chiropractors are ready to help them. No one has told them they have to work only between 9:00 and 5:00."

Dr. Sammons warned the audience that when President Reagan states he is going to cut spending, he intends to do so, and the health care budget will not escape the ax.

Board Actions of Major Importance

FMA Priorities 1983-84: The Board approved the following Association priorities for 1983-84: (A report on the status of the Association's activities in implementing the priorities will be included as Appendix 1 to Report C of the Board of Governors in the *Delegates' Notebook.)*

Membership

- The Association will continue to work toward a permanent solution to the professional liability crisis in Florida through legislative, judicial and constitutional remedies, as indicated.
- Develop programs to increase awareness among practicing physicians of the importance of maintaining a relationship with their patients which is responsive to their medical and emotional well-being and which fosters open communications between the patient and the physician.
- Develop, in cooperation with component county medical societies, the FMA Auxiliary, and FMA-recognized specialty societies, public relations programs designed to improve the image of organized medicine and the individual physician as perceived by the news media and the public including an awareness of the contributions that the medical community makes to society at all levels through the provision of quality health care and through the continued pursuit of advancements in medical technology and procedures to improve quality and longevity of life.
- Continued emphasis on a comprehensive and ongoing media relations program implemented in cooperation with component county medical societies.
- Continued efforts toward implementation of a statewide Impaired Physicians Program with a full-time medical director.
- Continued efforts to develop among FMA members an awareness of their individual responsibility for becoming actively involved, through organized medicine, in the decisions that will be made by the Legislature and other governmental bodies affecting the mechanisms and the level of health care delivery in Florida and throughout the country including, but not limited to, health care financing and system of health care delivery; i.e., Health Maintenance Organizations, Individual Practice Associations, Preferred Provider Organizations, Diagnostic Related Groups, health care competition, utilization review, peer review mechanisms, and other cost containment initiatives.
- Develop an awareness among FMA members of the factors underlying the increases in the cost of health care and evaluate the physician's role in addressing the concerns regarding health care costs.
- Continue efforts to improve communication and cooperation regarding programs and activities of the FMA with component county medical societies, the membership directly, and FMA-recognized specialty societies including maximum development of the GTE Telenet Medical Information Network in Florida.
- Continue to monitor the current relationships of physicians, individually and collectively, with hospitals and other health care facilities with appropriate actions, when indicated, to ensure preservation of the role of the physician as having primary responsibility and authority for the management of patient care but with productive interaction with allied health groups.
- Membership development at the county, state and national levels to include medical student and house staff representatives.
- Encourage FMA members to exercise their individual responsibility for becoming actively involved in community affairs and the political process including legislation and political action activities.
- The FMA will continue to explore every avenue to assure that physicians are equitably reimbursed for the services that they render to government-sponsored health care programs including the Florida Workers' Compensation program. The Association, following the directive of the 1983 FMA House of Delegates, will continue its efforts to achieve equitable payment for health care services which recognizes regional differentials in those counties where the total cost of health care delivery is demonstrated to be higher than the average for the remainder of the state.

Programs

- Continue efforts to inform the public, the Legislature, and the judiciary of the facts regarding the critical need to resolve the professional liability crisis and the deleterious effect that this problem is having upon the patient/physician relationship and the cost and quality of health care in Florida.
- Creation of a public awareness of the high level of quality and availability of health care in Florida and the contributions that the medical community makes on an ongoing basis to the preservation and quality of individual life, the public's health, and to the cultural growth of the community at large.
- That the Association actively participate in a cooperative effort with the Legislature, appropriate governmental bodies, and voluntary groups in the development and implementation of meaningful and equitable programs to respond to the concerns of the continuing increase in the cost of health care delivery with the primary goal of ensuring the continued provision of the highest level of quality medical care within the private free enterprise system of health care delivery including:

1. An objective assessment and reporting on the underlying causes of rising health care costs in Florida.
2. An evaluation of the impact of health care costs on the public with particular emphasis on Florida's increasing elderly population, the designated medically indigent, the unemployed, business and industry.
3. Informational programs for the purpose of advising FMA members, the public, the Legislature and other

3. governmental bodies on the positive and negative aspects of innovative initiatives and programs designed to cut or contain the cost of health care, such as Preferred Provider Organizations, Health Maintenance Organizations, Individual Practice Associations, health care competition, utilization review programs, peer review mechanisms and other cost containment initiatives.

- The Association will continue to promote and participate in programs addressing emergency medical services, the health needs of the aging, substance abuse, public health and school health that impact upon the health and well-being of all Floridians including:

  1. The implementation of the first-year recommendation of the FMF Emergency Medical Services Project.
  2. Providing medical leadership in the implementation of the AMA Prescription Abuse Data Synthesis (PADS) model through direct involvement with the appropriate state agencies and assuring a program of identification and referral of impaired physicians to the Committee on Impaired Physicians.
  3. Focusing on the problems of toxic substances in the environment and their impact on public health.
  4. Developing and promoting a uniform, statewide preathletic participation physical examination.

- The Association will increase its efforts to establish channels of communication and cooperation with voluntary health agencies, allied health groups, the Florida Hospital Association, medical professional organizations, senior citizen organizations and third-party carriers in order to create meaningful health care coalitions in Florida to address issues of mutual concern.
- Continue to work toward a cooperative relationship with other departments and agencies of state government in health care related issues.
- Seek direct physician participation at the policymaking level for health planning and other state-administered health care programs including the rulemaking process.
- The Association will continue to oppose vigorously the practice of medicine other than by medical or osteopathic physicians.
- The Association will strive to become the acknowledged leader in Florida in the promotion and coordination of scientific and educational medical activities including:

  1. Identifying physicians and non-physicians throughout Florida who have direct responsibility for the provision of continuing medical education activities and providing them with appropriate up-to-date information on CME and accreditation procedures and requirements.
  2. The development of an FMA booklet on CME explaining the Association's program.
  3. Providing assistance to county medical societies, specialty societies and hospitals relative to procedures and requirements for high-quality programs of CME.

- That pursuant to the actions of the FMA House of Delegates in May 1983, the Association, through the Florida Medical Foundation or other appropriate entity, apply for designation as the statewide peer review organization (PRO) in Florida as authorized under the Tax Equity and Fiscal Responsibility Act of 1982 (PL 97-248) for the purpose of promoting the efficient and economical delivery of health care services while assuring and promoting the quality of care rendered. It is the intent of the Association that, to the greatest extent possible, the FMF-PRO will through local county medical societies or their designated physician-established mechanisms implement the PRO activities at the local level. It is further the Association's intent that qualified physicians maintain primary responsibility and authority for the peer review process.

Public

- Continue to provide the public, governmental bodies and the news media with timely and responsive Association views on:

  1. The seriousness of the problem of professional liability and cost of health care liability insurance in Florida and how it affects all segments of society.
  2. Preventive health care educational programs.
  3. Health of the public.
  4. Standards for health care delivery and qualified health care professionals including health planning and qualified review of the quality and appropriateness of health care delivery.
  5. The underlying factors of the cost of health care.
  6. Alternative health care delivery systems.
  7. Health care financing initiatives.
  8. The role of government in health care delivery.

American Medical Association (AMA)

- Continue efforts for AMA membership development.
- Cooperative effort to coordinate programs and activities at all levels of the Federation.
- That the AMA be encouraged to make every effort to create a greater public awareness of the high level of quality and availability of health care in this country and the contributions that the medical community makes to society at all levels through the provision of quality health care and through continued pursuit of advancements in medical technology and procedures by physicians to improve the quality and longevity of life, and to the cultural growth of their community.
- Encourage the AMA to actively create an awareness among the Congress, other governmental bodies, and the public of the severe litigation problem in this country particularly the professional medical liability problem and the deleterious effect that it is having on the cost and quality of health care.
- The the AMA continue to address before Congress and other governmental bodies organized medicine's views on the standards for health care delivery and qualified health care professionals, the underlying factors affecting the cost of health care, the positive and negative aspects of innovative cost containment initiatives, and that the AMA continue to exert its full efforts to ensure the preservation of the country's private free enterprise system of health care delivery.

Issues

- Medical professional liability.
- Cost of medical care.
- Improving the patient/physician relationships and communication.
- Public awareness of the contributions of medicine to the quality of society.
- Continued opposition to any compulsory comprehensive national health insurance program.
- Opposition to the practice of medicine by other than medical or osteopathic physicians.
- Alternative health care delivery systems.

Finance: The Association had income during 1983 from all sources of $3,426,599. Total expenditures during the year were $3,483,061 which is $56,462 more than was received in income. The figures do not reflect expenditures for equipment or depreciable items as they are a transfer from liquid to fixed assets. The net worth of the Association as of December 31, 1983 was $3,414,878.

The House of Delegates in 1982 authorized, at the discretion of the Board, a $50.00 mandatory assessment of all FMA active members for professional liability. The Board, at its meeting on August 8, 1982, determined the assessment was needed to carry out the Association's professional liability program. As of the date of this report, total funds collected have been $547,050 with interest earned of $22,368. Total expenditures to date are $497,414 and the balance in the fund is $72,004.

The House of Delegates in 1980 authorized the Board of Governors to establish a special trust fund for the current and future reserves of the Association, the initial funding coming from the approximately $600,000 profit from the sale of the headquarters building in Jacksonville. The Trustees of this fund are the three (3) immediate past living presidents of the Association, including the Immediate Past President who is an officer. The principal and interest of these funds accrue in this trust account which shall be established in the name of the Association in an escrow trust. The Trustees may release the funds upon request of the Board of Governors which indicates that an emergency exists which cannot be financed through regular income or assets of the Association. In the event the Trustees do not agree to release the funds, the Board of Governors may direct their release upon ¾ vote of the active members of the Board of Governors.

The net proceeds from the sale of the FMA property at 801 Riverside Avenue and the purchase of 760 Riverside Avenue left a net of $137,000 and, as directed by the Board, was placed in the reserve fund

The first three annual principal payments on the mortgage held by the FMA on the 801 property of $203,743.66 were placed in this trust fund. The interest earned through December 31, 1983 in the fund was $75,655.00 and the total balance in the trust fund as of December 31, 1983 was $416,398.66.

The Board reviewed the financial statements and proposed 1984 budget presented by the Treasurer, Executive Vice President and Executive Director. The Board approved the proposed budget for 1984 for the total anticipated income from all sources and expenditures in the amount of $3,245,000. In keeping with the policy established by the House of Delegates, $50.00 of each member's dues was budgeted to public relations and legislative activities.



Always with camera in hand is John W. Glotfelty, M.D., Editor of the Polk County Medical Association Bulletin pictured here with Mrs. Glotfelty (Bonnie).



Newly elected FMA Secretary Henry M. Yonge, M.D., of Pensacola, addresses the House of Delegates.

The audit conducted by the Association's CPA firm of Harbeson, Beckerleg and Fletcher for the year ending December 31, 1983, is available for inspection by any member of the Association who may wish to review it.

Management: In compliance with the request of the Executive Vice President to be relieved of his responsibilities with the Association by April 2, 1984, except for attending the Annual Meeting in May (ending 35 years of service), the Board of Governors appointed a special Committee on Management in May 1980 to study and make recommendations regarding the position of the Association's Chief Executive Officer and the transition period.

The Board of Governors in 1981 approved reorganization of FMA senior staff responsibilities and further directed that the Executive Vice President, W. Harold Parham, D.H.A., retain responsibility for finances and policy implementation and continue to transfer all operational responsibilities to the Executive Director, Donald C. Jones. The Board of Governors reported to the House of Delegates at its 1982 Annual Meeting that the transition in management was proceeding in a satisfactory manner including the designation of the Executive Director as the Chief Executive Officer as of January 1982.

The Committee on Management continued during the transition period to evaluate the performance of the senior executive staff. The Committee reported that during the current Association year the transition of the FMA management responsibility of the Executive Vice President to the Executive Director had been carried out in an orderly and highly efficient manner in every respect.

The Board at its meeting in June 1983 determined that the management committee not be reappointed and that the FMA Executive Committee reassume its function as the management committee.

AMA Resolution of Commendation of W. Harold Parham, D.H.A.: The AMA House of Delegates, at its First Session during the Interim Meeting in December 1983, honored Dr. Parham and adopted a resolution introduced by the Florida AMA Delegates, on behalf of the FMA, acknowledging medicine's indebtedness to Dr. Parham for his dedication, devotion, energy and talents, and for his tireless efforts in behalf of medicine for 35 years (a copy of

the resolution will be included as Appendix 2 to Report C of the Board of Governors in the *Delegates' Handbook).*

Future Annual Meeting Dates: The Board reconfirmed on a definite basis the FMA Annual Meeting dates scheduled at the Diplomat Hotel for May 1-5, 1985 and May 13-17, 1987, and that the May 14-18, 1986 and May 11-15, 1988 Annual Meeting dates be scheduled on a tenative basis in the central Florida area.

House of Delegates Ratio: The Board approved continuation of the current allocation of delegates of one delegate for every 50 active members as the ratio for determining delegates for the 1984 Annual Meeting.

FMA Award Procedures: To help expedite the business of the House, the Board approved presentation of various FMA awards during the Annual Meeting as follows:

First House of Delegates
The A.H. Robins Company Award for Outstanding Community Service by a Physician
Distinguished Layman Award
Medical Malpractice Prevention Award
Medical Speakers' Awards
Good Samaritan Award
Medical Journalism Awards
JFMA Awards for County Medical Society Bulletins — Acknowledged, and included in *Delegates' Notebook*. The awards will be presented at the Editor's Dinner.

General Session
Scientific Exhibit Award Announcements

Second House of Delegates
Certificate of Merit
Certificate of Appreciation

The Board further recommended to the Speaker that the House of Delegates convene at 3:30 p.m. on Wednesday instead of 4:30 p.m., and that more prominence be given to the Presidential Address.

FMA Awards

The Board approved the following FMA awards to be continued for 1984 as part of the FMA's public relations activities:

Medical Journalism Awards
Medical Speakers' Awards
Medical Malpractice Prevention Award

Good Samaritan Award: The Board approved the criteria for selecting the recipient of the Harold S. Strasser, M.D., Good Samaritan Award established by the House of Delegates at its meeting in May 1983:

That the Harold S. Strasser, M.D., Good Samaritan Award be awarded when appropriate and selected by the Board of Governors from nominations submitted by county medical societies, FMA-recognized specialty groups and hospital medical staffs;

That the recipient of this award must be a member of the Florida Medical Association, either active or retired. His or her nomination must cite and document a distinct act(s) of humanitarian and/or good samaritan activity, must be above and beyond the high standard of conduct normally expected of physicians and normally would not include devoted or loyal service to the recipient's own patients; acts of humanitarian or good samaritan activity may be toward single individuals or groups of people. Each act cited should in some way demonstrate the recipient's love and compassion for his fellow man without concern for his/her own comfort, safety and welfare. Examples of these acts include:

- *Rendering medical care voluntarily and without being asked to do so at the scene of an accident or disaster;*
- *Leadership or active involvement in disaster relief efforts without regard to his/her own safety or welfare.*

That a selection committee be appointed by the FMA President to review nominations and to make recommendations to the Board regarding the recipient;

That nominations be submitted in conjunction with those for other FMA awards during any appropriate year;

That the award be presented at the time of the FMA Annual Meeting.

A.H. Robins Award: The Board reviewed nominations received from county medical societies and selected the recipient of the 1984 A.H. Robins Award "For Outstanding Community Service by a Physician". This award will be presented at the First Meeting of the House of Delegates on May 2, 1984.

Distinguished Layman Award: The Board has selected the 1984 recipient of the Distinguished Layman Award. The appropriate citation, along with the criteria, will be included in the *Delegates' Notebook.*

Nominations

Certificate of Merit: The Board selected an outstanding physician for nomination to the House of Delegates to receive the Certificate of Merit for 1984 (the Association's highest honor of achievement). This nomination will be included in the *Delegates' Notebook* for approval by the House of Delegates.

Certificate of Appreciation: The Board selected two physicians to be nominated to the House of Delegates as recipients of the 1984 Certificate of Appreciation. These nominations will be included in the *Delegates' Notebook* for approval by the House of Delegates.

FMA Election Procedures: The Board of Governors considered a report and recommendation for modifications to the current election procedures of the Association for future Annual Meetings similar to those procedures utilized by the American Medical Association.

RECOMMENDATION NO. C-1

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING MODIFICATIONS TO THE ELECTION PROCEDURES OF THE ASSOCIATION:

A. THAT NOMINATIONS FOR OFFICERS OF THE ASSOCIATION AND DELEGATES TO THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION BE HELD ON THE DAY BEFORE THE FINAL SESSION OF THE HOUSE (SATURDAY).
B. ELECTION VOTING WILL OCCUR BETWEEN 7:00 A.M. AND 9:00 A.M. ON THE DAY OF THE FINAL SESSION OF THE HOUSE (SUNDAY).
C. PRINTED BALLOTS WILL BE UTILIZED IN ELECTION VOTING PROCEDURES AND DEPOSITED IN BALLOT BOXES LOCATED IN PRIVATE VOTING BOOTHS.
D. IF NO CANDIDATE RECEIVES A MAJORITY VOTE, OR IN THE EVENT OF A TIE VOTE, A RUNOFF WILL BE HELD DURING THE FINAL SESSION OF THE HOUSE (SUNDAY). BALLOTS WILL BE DISTRIBUTED TO DELEGATES AND THE RESULTS ANNOUNCED ONCE THE VOTE HAS BEEN TALLIED.

To implement these changes in the election procedures require modifications to the Bylaws of the Association.

RECOMMENDATION NO. C-2

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING MODIFICATIONS TO THE BYLAWS OF THE ASSOCIATION REGARDING ELECTIONS:

CHAPTER V
ELECTIONS

Section 4. NOMINATIONS

~~Nominations for officers of the Association and delegates to the House of Delegates of the American Medical Association shall be made from the floor of the House of Delegates by a member of the House. All active members of the Association are eligible for nomination. Nominating and seconding speeches shall be limited to a maximum of two minutes.~~

NOMINATIONS FOR OFFICERS OF THE ASSOCIATION AND DELEGATES AND ALTERNATE DELEGATES TO THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION SHALL BE MADE FROM THE FLOOR OF THE HOUSE OF DELEGATES BY A MEMBER OF THE HOUSE. ALL ACTIVE MEMBERS OF THE ASSOCIATION ARE ELIGIBLE FOR NOMINATION. NOMINATING AND SECONDING SPEECHES SHALL BE LIMITED TO A MAXIMUM OF TWO MINUTES AND WILL BE HELD PRIOR TO THE FINAL SESSION OF THE HOUSE.

~~deleted language~~ **NEW LANGUAGE**

CHAPTER V
ELECTIONS

Section 5. TIME AND PLACE

~~The election of officers of the Association and delegates to the House of Delegates of the American Medical Association shall be held during the final session of any meeting of the House of Delegates. Only seated delegates shall be eligible to vote.~~

THE ELECTION OF OFFICERS OF THE ASSOCIATION AND DELEGATES TO THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION SHALL BE HELD ON THE DAY OF THE FINAL SESSION OF THE HOUSE OF DELEGATES. ONLY SEATED DELEGATES SHALL BE ELIGIBLE TO VOTE.

~~deleted language~~ **NEW LANGUAGE**

Separation of FMA Annual Meeting: The Board disapproved a recommendation that the FMA consider dividing the Annual Meeting and that two meetings be held, one scientific and one business, with the business meeting to be held at an appropriate time before the Legislature convenes in order to finalize the FMA's legislative program.

Medical Seminars: The Board approved the following medical travel seminars for 1984:

— South Pacific Adventure, January/February 1984 (15 days)
— Danube River Adventure, August 1984 (13 days)
— Far East Adventure, September 1984 (15 days)
— Mediterranean/Greek Isles Air/Sea Cruise, October 1984 (14 days)

Complimentary FMA Journals: The Board approved a one-year pilot program to provide a complimentary subscription to *The Journal of the Florida Medical Association, Inc.*, to all senior medical students in Florida's three medical schools.

Council on Specialty Medicine, Composition and Function: The Board at its meeting in June 1983, appointed a subcommittee of the Board to review the current criteria for appointment to the Council on Specialty Medicine and its functions, and submit recommendations to the Board.

In evaluating the appointments to the Council and its functions, the Committee considered the following:

- The criteria for recognition of specialty groups.
- The role of the Council on Specialty Medicine as set forth in the FMA Bylaws, Chapter VIII, Section 3, which includes to provide harmony and cohesiveness to the general body of medicine.
- The relationship which currently exists between the other 49 state medical associations and specialty groups as determined by a survey conducted by AMA in March 1982, and a survey conducted by the FMA in August 1983:
    - Thirty-one state medical associations have a formal mechanism (i.e., council or committee) for specialty group activities.
    - Forty state medical associations provide administrative services to specialty groups.
    - Twenty-two state medical associations allow specialty group representation in their House of Delegates.

Observations

The Committee discussed in-depth the historical activities of the Council on Specialty Medicine since its inception in 1960. The Committee recognizes that in practice the current method of appointments to the Council has not always proven desirable in that the specialty group representatives have not consistently fully represented the views of the society that they represent. The Committee also recognizes that the functions of the Council have not always been in total accord with its duties and functions as outlined in the FMA Bylaws. However, the Committee feels that in light of the many challenges facing medicine at all levels, the FMA should exert every effort possible to preserve and enhance unity and cooperation in the house of medicine at all levels and that the Association should seek to foster cohesiveness and cooperation with its recognized specialty groups. Therefore, the Committee feels that the FMA should not in any way overtly diminish the role of the Council on Specialty Medicine or take any action that diminishes the positive input and participation of specialty groups in FMA activities.

RECOMMENDATION NO. C-3

THAT THE HOUSE OF DELEGATES APPROVE THE RECOMMENDATION THAT NO CHANGE BE MADE AT THE PRESENT TIME IN THE CURRENT CRITERIA FOR APPOINTMENT OF THE COUNCIL ON SPECIALTY MEDICINE OR ITS FUNCTION.

RECOMMENDATION NO. C-4

(Not adopted — Referred to Board of Governors)

THAT THE HOUSE OF DELEGATES APPROVE AN AMENDMENT TO THE FMA BYLAWS TO PROVIDE THAT EACH FMA RECOGNIZED SPECIALTY GROUP BE ALLOWED ONE VOTE IN THE FMA HOUSE OF DELEGATES.

Following the completion of Recommendation No. C-4 of Report C of the Board of Governors, the Speaker suspended the remainder of the report of Reference Committee III until the Third House in order to allow for nomination of officers and AMA Delegates and Alternates.

Speaker of the House
Vice President
Treasurer
AMA Alternate Seat #2
AMA Delegate Seat #3
AMA Alternate Seat #3
AMA Delegate Seat #5
AMA Alternate Seat #5
AMA Delegate Seat #9
AMA Alternate Seat #9
AMA Delegate Seat #10
AMA Alternate Seat #10
AMA Delegate Seat #11
AMA Alternate Seat #11

Vice Speaker, Dr. McKechnie, received a motion from the floor to elect by acclamation candidates for Speaker of the House, Vice President, Treasurer, AMA Delegate Seats 3, 5, 9, 10, 11 and Alternate Seats 2, 3, 5, 9, 10 and 11, all of whom are incumbents and unopposed. The motion carried unanimously and the following candidates were elected:

Speaker of the House — James B. Perry, M.D.
Vice President — James G. White, M.D.
Treasurer — Yank D. Coble Jr., M.D.
AMA Alternate Seat #2 — James M. Perry, M.D.
AMA Delegate Seat #3 — Charles K. Donegan, M.D.
AMA Alternate Seat #3 — Frank C. Coleman, M.D.
AMA Delegate Seat #5 — Richard G. Connar, M.D.
AMA Alternate Seat #5 — Vernon B. Astler, M.D.
AMA Delegate Seat #9 — Robert E. Windom, M.D.
AMA Alternate Seat #9 — William B. Deal, M.D.
AMA Delegate Seat #10 — Luis M. Perez, M.D.
AMA Alternate Seat #10 — Arthur L. Eberly Jr., M.D.
AMA Delegate Seat #11 — Sanford A. Mullen, M.D.
AMA Alternate Seat #11 — Dick L. Van Eldik, M.D.

The new terms for Delegate Seats 3, 5, 9, 10 and 11 and Alternate Seats 2, 3, 5, 9, 10 and 11 are for two years (January 1, 1985 to December 31, 1986).

Elections

President-Elect

The Vice Speaker opened the floor for nominations for the office of President-Elect. Dr. Maria Perez of Seminole County nominated Dr. Luis M. Perez of Seminole County. The nomination was seconded by Dr. James F. Richards of Seminole County; Dr. Daniel L. Seckinger of Dade County; Dr. Charles B. McIntosh of Duval County; Dr. Charles J. Kahn of Escambia County; Dr. Robert N. Webster of Capital County; Dr. Burns A. Dobbins Jr. of Broward County; Dr. Thomas E. McKell of Hillsborough County; Dr. Charles P. Gibbs of Alachua County; and Dr. Walter H. Winchester of Pinellas County.



Frederick J. Weigand, M.D., President of the Seminole County Medical Society, escorts Dr. Maria P. Perez to the podium to nominate her husband, Luis M. Perez, M.D., as President-Elect of the Florida Medical Association.

Secretary

The floor was opened for nominations for the office of Secretary. Dr. Lee A. Fischer of Palm Beach County nominated Dr. Dick L. Van Eldik of Palm Beach County. The nomination was seconded by Dr. Margaret C.S. Skinner of Dade County; Dr. Wilbert L. Dawkins of Duval County; Dr. Donald G. Nikolaus of Pinellas County; Dr. Clarence M. Gilbert of Orange County; Dr. Arthur L. Eberly Jr. of Broward County; and Dr. Kenneth C. Kiehl of Sarasota County.

Dr. James M. Potter of Escambia County nominated Dr. Henry M. Yonge of Escambia County for Secretary. The nomination was seconded by Dr. Robert

E. Boyett of Dade County; Dr. Clyde M. Collins of Duval County; Dr. Thomas E. McKell of Hillsborough County; Dr. O. Frank Agee of Alachua County; Dr. Calvin W. Martin of DeSoto-Hardee-Glades County; and Dr. Kay K. Hanley of Pinellas County.

Vice Speaker

Dr. McKechnie advised the House that due to a conflict of interest he was resigning as Vice Speaker of the House. He thereupon opened the floor for nominations for the office of Vice Speaker. Dr. Robert H. Threlkel of Duval County nominated Dr. Guy T. Selander of Duval County. The nomination was seconded by Dr. Dolores A. Morgan of Dade County; Dr. Arthur L. Eberly Jr. of Broward County; Dr. Theodore J. Marshall of Escambia County; Dr. Joseph G. Matthews of Orange County; Dr. Kay K. Hanley of Pinellas County; and Dr. Calvin W. Martin of DeSoto-Hardee-Glades County.

AMA Delegate - Seat #2

The Speaker opened the nominations for AMA Delegate Seat #2 for a term that begins January 1, 1985 and ends December 31, 1986.

Dr. A. Frederick Schild of Dade County nominated Dr. Joseph T. Ostroski of Dade County. The nomination was seconded by Dr. James A. Winslow Jr. of Hillsborough County; Dr. William H. Meyer Jr. of St. Lucie-Okeechobee County; and Dr. Ernest G. Sayfie of Broward County.

Dr. Samuel M. Day of Duval County nominated Dr. James W. Walker of Duval County. The nomination was seconded by Dr. Richard C. Rehmeyer of Sarasota County.

AMA Alternate - Seat #7 or #8
(Contingent upon results of election for AMA Delegate - Seat #2)

The Vice Speaker advised the House that because Drs. Ostroski and Walker have both been nominated as an AMA Delegate for Seat #2, that a vacancy would then result in either AMA Alternate Seat #7 or AMA Alternate Seat #8 as a result of the election for AMA Delegate Seat #2.

The floor was opened for nominations for AMA Alternate Seat #7 or #8 for a term that begins January 1, 1985 and ends December 31, 1986.

Dr. James R. Forlaw of Palm Beach County nominated Dr. Lee A. Fischer of Palm Beach County. The nomination was seconded by Dr. Herbert E. Brooks of Panhandle County and Dr. Charles A. Dunn of Dade County.

Dr. Charles P. Gibbs of Alachua County nominated Dr. J. Lee Dockery of Alachua County. The nomination was seconded by Dr. Robert E. Boyett of Dade County; Dr. Thomas M. Daniel of Pinellas County; Mr. James B. Dolan of Alachua County; Dr. O. William Davenport of Dade County; and Dr. Ernest G. Sayfie of Broward County.

Judicial Council

The Speaker referred the House to the Report of the Board of Governors (Report F) in which the Board had nominated Kenneth C. Kiehl, M.D. of Sarasota to a five year term, expiring in 1989, on the Judicial Council as a representative from District B.

Committee on Membership and Discipline

The Speaker referred the House to the nominations for election to the Committee on Membership and Discipline as submitted by the Board of Governors in its report (Report F) and advised the House that he would entertain any additional nominations from the floor. The Speaker thereupon announced the names of the nominees from each district:

District 1:	Robert C. Palmer, M.D. (88)
District 2:	James T. Cook Jr., M.D. (88)
District 3:	John A. Rush, M.D. (88)
District 4:	Richard W. Snodgrass, M.D. (88)
District 5:	Clarence M. Gilbert, M.D. (88)
District 6:	David A. Johnson, M.D. (88)
District 7:	William B. Hopkins, M.D. (88)
District 8:	John T. Karaphillis, M.D. (88)
District 9:	Joseph P. Levine, M.D. (88)
District 10:	Wiley E. Koon, M.D. (88)
District 11:	John O. Rao, M.D. (88)
District 12:	Robert Burger, M.D. (88)
District 13:	David L. Thomas, M.D. (88)
District 14:	William J. Romanos Jr., M.D. (88)
District 15:	Wayne G. Riskin, M.D. (88)
District 16:	Nester C. Guaty, M.D. (88)
District 17:	Richard C. Clay, M.D. (88)
District 18:	Jerome Benson, M.D. (88)
District 19:	Rufus K. Broadaway, M.D. (88)

The Speaker then announced that balloting would commence at 7:00 a.m. on Sunday, prior to the opening session of the Third House of Delegates.

The meeting of the Second House of Delegates recessed at 6:35 p.m. to reconvene on Sunday, May 6, 1984, at 9:00 a.m.

Auxiliary Highlights





(1) Left to right: Beebe White (James), Treasurer; Sandra Whittaker (David), Secretary; Jane Eberly (Arthur L.), DVP South; Mary Turner (Jerald), DVP West Central; Martha Cox (Gene), DVP Southwest; Eleanor Griffin (Taylor), DVP East Central; Jodie Jarrell (Walter), DVP Northeast; Helen Holmes (Thomas), DVP Northwest; Susan Marks (V.A.), First Vice-President; Jo Tignor (Milton), President-Elect; Nancy Smith (Laurin G.), President. (2) U.S. Senator William S. Cohen of Maine addresses the annual Auxiliary/FLAMPAC Luncheon. (3) Immediate Past President Mrs. Daniel B. (Gloria) Nunn presents the Past President's Pin to Mrs. S. Bruce (Priscilla) Gerber. (4) Outgoing Auxiliary President Mrs. S. Bruce (Priscilla) Gerber awards the President's Pin to Mrs. Laurin G. (Nancy) Smith of Vero Beach.





(5) FMA and FMA Auxiliary leadership stand together as FMA President-Elect Frank C. Coleman, M.D. (center) congratulates FMA Auxiliary President Mrs. S. Bruce (Priscilla) Gerber and President-Elect Mrs. Laurin G. (Nancy) Smith. (6) FMA Auxiliary President Mrs. Laurin G. (Nancy) Smith. (7) Standing: Mrs. Jane Eberly. Seated: Mrs. Sue Burtolette, President, Indian River County. (8) Left to right: Mrs. V.A. (Susan) Marks, First Vice- President; Mrs. Milton (Jo) Tignor, President-Elect; and Mrs. Laurin G. (Nancy) Smith, President. (9) Mrs. Guy T. (Joan) Selander, AMA-ERF Chairman, Eugene G. Peek Jr., M.D., and Mrs. S. Bruce (Priscilla) Gerber.


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Editor's Dinner





















Editors of The Journal assembled on Thursday night for their annual banquet. JFMA Editor Daniel B. Nunn, M.D. presided at the gathering which has become an annual meeting highlight. (1) Dr. Nunn presents a bound volume of the JFMA to President-Elect Frank C. Coleman, M.D. of Tampa. (2) Dr. Nunn expresses appreciation to his Associate and Assistant Editors and Editorial Staff. (3) JFMA Editor Daniel B. Nunn, M.D. and Mrs. Nunn (Gloria) await guests for the annual Editor's Dinner. (4) Past Editor Gerold L. Schiebler, M.D. of Gainesville receives his annual bound volume of The Journal. (5) F. Norman Vickers, M.D. accepts his bound volume of The Journal. (6) Associate Editor E. Charlton Prather, M.D. (left) enjoys a comment by Associate Editor and former JFMA Editor Clyde M. Collins, M.D. (7) Associate Editor E. Charlton Prather, M.D. accepts his bound volume of The Journal. (8) Dr. Maria Perez (left), FMA Secretary Luis M. Perez, M.D. and Mrs. Daniel B. (Gloria) Nunn enjoy a light-hearted moment. (9) The Editor's children, Myra and Daniel, enjoyed the festivities at the annual Editor's Dinner. (10) Former JFMA Editor Clyde M. Collins, M.D. pays tribute to Daniel B. Nunn, M.D., JFMA Editor.

Third House of Delegates

The third meeting of the House of Delgates convened at 9:00 a.m. on Sunday, May 6, 1984, in the Great Hall North of the Buena Vista Palace Hotel, Lake Buena Vista, Florida, with the Speaker of the House, Dr. James B. Perry, presiding.

Dr. Dolores A. Morgan of the Credentials Committee reported that 246 delegates were registered, representing 40 county societies, which constitutes a quorum, and moved that the delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; Mark V. Barrow, M.D.; Thomas D. Bartley, M.D.; William B. Deal, M.D.; Charles P. Gibbs, M.D.; William T. Hawkins, M.D.; D. Orvin Jenkins, M.D.; Mr. James B. Dolan, Student Delegate.

BAY — James T. Cook III, M.D.; Terrence R. Steiner, M.D.; (Absent — William G. Bruce, M.D.)

BREVARD — Richard I. Barr, M.D.; James E. Carter, M.D.; Walter A. Cerrato, M.D.; Robert C. Ufferman, M.D.; Joseph C. Von Thron, M.D.; (Absent — Raymond A. Armstrong, M.D.; Ovidio E. Vitas, M.D.)

BROWARD — Bruce B. Burgess, M.D.; Andre S. Capi, M.D.; David A. D'Alessandro, M.D.; Arthur L. Eberly, M.D.; George Edwards, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; Theodore W. Hahn, M.D.; Wilbur F. Helmus, M.D.; Theodore C. Lescher, M.D.; George P. Messenger, M.D.; Alexander E. Molchan, M.D.; Ray E. Murphy Jr., M.D.; Donald J. Plevy, M.D.; Ernest G. Sayfie, M.D.; Richard D. Shafron, M.D.; Marvin L. Stein, M.D.; H. Murray Todd, M.D.; Alan J. Yesner, M.D.; (Absent — Phillip A. Caruso, M.D.; William C. Hartley, M.D.; James A. Jordan, M.D.; David C. Lane, M.D.; Jerry D. Moore, M.D.; Joseph Sachs, M.D.; Richard D. Schultz, M.D.; Peter A. Tomasello, M.D.; Anthony J. Vento, M.D.; Juan S.A. Wester, M.D.)

CAPITAL — Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Robert N. Webster, M.D.

CHARLOTTE — Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; (Absent — Jaime Torner, M.D.)

CITRUS — Alexander E. Hlivko, M.D.; W. Randall Jenkins, M.D.

CLAY — Clarence M. Harris, M.D.; Hinson L. Stephens, M.D.

COLLIER — Charles J. Montgomery, M.D.; Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.

COLUMBIA — Leela Swamy, M.D.

DADE — Edward R. Annis, M.D.; Jerome Benson, M.D.; Jose S. Bocles, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; Herman Cohen, M.D.; Vincent P. Corso, M.D.; O. William Davenport, M.D.; Norman T. Ditchek, M.D.; Charles A. Dunn, M.D.; Richard J. Feinstein, M.D.; Miguel Figueroa, M.D.; N. Ralph Frankel, M.D.; Richard L. Glatzer, M.D.; Alan S. Graubert, M.D.; Joan Harris, M.D.; James J. Hutson, M.D.; Jesse G. Keshin, M.D.; Maurice H. Laszlo, M.D.; Warren Lindau, M.D.; Simon E. Markovich, M.D.; Dolores A. Morgan, M.D.; Sheldon D. Munach, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Wayne Porter, M.D.; Sorrel S. Resnick, M.D.; Julian A. Rickles, M.D.; William I. Roth, M.D.; Sylvan H. Sarasohn, M.D.; Eugene R. Schiff, M.D.; Daniel L. Seckinger, M.D.; Barry M. Seinfeld, M.D.; Margaret C.S. Skinner, M.D.; Samuel P. Stokley, M.D.; Chauncey M. Stone, M.D.; Osvaldo D. Valdes, M.D.; Edgar W. Webb, M.D.; Harold H. Weiner, M.D.; Sheldon Zane, M.D.; Ms. Ana Isabel Gonzalez, Student Delegate; (Absent — Harlon S. Chiron, M.D.; Richard C. Clay, M.D.; Joseph H. Davis, M.D.; Julian H. Groff, M.D.; Joseph Harris, M.D.; Walter C. Jones III, M.D.; Norman M. Kenyon, M.D.; Carlos G. Llanes, M.D.; Morton L. Miller, M.D.; Jose R. Pujols Bosch, M.D.; Arnold F. Schild, M.D.; Everett Shocket, M.D.; Douglas Slavin, M.D.; Charles F. Tate, M.D.; Steven M. Weissberg, M.D.; Edmund K. Zahn, M.D.)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Gaston J. Acosta-Rua, M.D.; Samuel J. Alford Jr., M.D.; Yank D. Coble, M.D.; Clyde M. Collins, M.D.; Wilbert L. Dawkins, M.D.; Samuel M. Day, M.D.; Richard C. Dever, M.D.; William J. Garoni Jr., M.D.; Walter A. Harmon, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; John F. Lovejoy Jr., M.D.; Kevin M. McAuliffe, M.D.; Charles B. McIntosh, M.D.; Guy T. Selander, M.D.; Seabury D. Stoneburner Jr., M.D.; Robert H. Threlkel, M.D.; George S. Trotter, M.D.; James W. Walker, M.D.; William D. Walklett, M.D.

ESCAMBIA — Richard H. Ciordia, M.D.; Charles J. Kahn, M.D.; Theodore J. Marshall, M.D.; Charles F. McConnell, M.D.; Michael R. Redmond, M.D.; Robert K. Wilson Jr., M.D.; Henry M. Yonge, M.D.

FLAGLER — John M. Canakaris, M.D.

FRANKLIN-GULF — (Absent — Joseph P. Hendrix, M.D.)

HERNANDO — Clinton J. McGrew Jr., M.D.

HIGHLANDS — Joseph A. Mitchell, M.D.; Luis M. Pena, M.D.

HILLSBOROUGH — Richard A. Bagby, M.D.; Lewis H. Berger, M.D.; Frank C. Coleman, M.D.; Richard G. Connar, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Richard S. Hodes, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Benedict S. Maniscalco, M.D.; Thomas E. McKell, M.D.; Robert E. McCammon,

M.D.; Ralph E. Rydell, M.D.; Ronald L. Seeley, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D.; Mr. Roland Reeves, Student Delegate

INDIAN RIVER — Randall D. Bertolette, M.D.; James W. Large, M.D.; Paul W. Taylor, M.D.

LAKE — Joseph A. Comfort, M.D.; Joseph E. Holland, M.D.; Robert H. Hux, M.D.

LEE — Ronald D. Castellanos, M.D.; Larry P. Garrett, M.D.; H. Quillian Jones Jr., M.D.; Stephen R. Zellner, M.D.; (Absent — Francis L. Howington, M.D.; Joseph P. O'Bryan, M.D.)

MADISON — (Absent — Michael O. Stick, M.D.)

MANATEE — Thomas R. Busard, M.D; Julian Giraldo, M.D. Roger A. Meyer, M.D.; James T. Rogers Jr., M.D.; (Absent — William A. Boyce, M.D.)

MARION — Claude B. Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; Andrew F. Greene, M.D.; (Absent — George E. McLain, M.D.)

MONROE — Ronald H. Chase, M.D.

NASSAU — (Absent — Jose L. Castillo, M.D.)

OKALOOSA — David R. Arrowsmith, M.D.; Samuel M. Atkinson Jr., M.D.

ORANGE — Edward Ackerman, M.D.; Richard J. Bagby, M.D.; Clifford D. Bidwell, M.D.; Manuel J. Coto, M.D.; Clarence M. Gilbert, M.D.; Wayne L. Godbold, M.D.; David L. Mackey, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Wallace M. Philips Jr., M.D.; Charles T. Price, M.D.; James E. Richards Jr., M.D.; Robert N. Serros, M.D.; Edward W. Stoner, M.D.; Cecil B. Wilson, M.D.

OSCEOLA — Gilberto Perez, M.D.; (Absent — Robert E. McMillen, M.D.)

PALM BEACH — Vernon B. Astler, M.D.; J.A. Baker, M.D. Robert Burger, M.D.; Richard C. Cavanagh, M.D.; McKinley Chesire, M.D.; Richard A. Chidsey, M.D.; Ralph R. Eastridge, M.D.; Lee A. Fischer, M.D.; James R. Forlaw, M.D.; James M. Johnson, M.D.; V.A. Marks, M.D.; Myron M. Persoff, M.D.; William J. Romanos Jr., M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D.; H. Peter Wintrich, M.D.; Harold Yount, M.D.

PANHANDLE — Herbert E. Brooks, M.D.

PASCO — Robert May, M.D.; Ross G. Olson, M.D.; Herman R. Reno, M.D.

PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; John Flint, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris J. LeVine, M.D.; Jack A. MaCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Howard L. Reese, M.D.; William H. Schmid, M.D.; Bruce P. Smith, M.D.; Walter H. Winchester, M.D.; (Absent — John M. Hamilton, M.D.)

POLK — Ronald W. Case, M.D.; Thomas M. Caswall, M.D.; John W. Glotfelty, M.D.; Wiley E. Koon, M.D.; John C. Moore, M.D.; Robert B. Peddy, M.D.; David Stoler, M.D.; (Absent — Saul B. Gerber, M.D.)

PUTNAM — (Absent — Edward D. Risch, M.D.)

ST. LUCIE-OKEECHOBEE — Charles R. Cambron, M.D.; William H. Meyer Jr., M.D.; (Absent — David L. Fromang, M.D.)

SARASOTA — John N. Carlson, M.D.; Samuel E. Kaplan, M.D.; Kenneth C. Kiehl, M.D.; Douglas R. Murphy, M.D.; Franklin H. Pfeiffenberger, M.D.; Richard C. Rehmeyer, M.D.; Karl R. Rolls, M.D.; David L. Thomas, M.D.

SEMINOLE — Jorge A. Gomez, M.D.; Luis M. Perez, M.D.; Maria P. Perez, M.D.

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Philip L. Carey, M.D.)

TAYLOR — John H. Parker, M.D.

VOLUSIA — Kenneth P. Derbenwidk, M.D.; Martin S. Feigenbaum, M.D.; Roger K. Lewis, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Charles A. Stump, M.D.

WALTON — (Absent — Howard F. Currie, M.D.)

WASHINGTON — Muhammad Amin, M.D.

SPEAKER OF HOUSE — James B. Perry, M.D.

VICE SPEAKER — Franklin B. McKechnie, M.D.

The Speaker advised that the first order of business was the introduction of distinguished guests and proceeded to introduce Dr. Rufus K. Broadaway, AMA Trustee who was asked to approach the podium and address the House.

Remarks — Rufus K. Broadaway, M.D. AMA Trustee

Speaker, Mr. President, Officers, Delegates. I am terribly proud to be your representative on the national level and I am greatly honored to be able to say a few words to you this morning.

I want to talk to you about the largest organization of doctors in the world; an organization that represents every doctor in this country, member or not. Every state sends its voting representative to this organization's policy-making body and every member is represented through these delegates. Each of 62 specialty societies has a voting representative in this House of Delegates. Policy is determined through debate at the local and state levels and is brought to this body for final decision through a democratic process that involves literally thousands of practicing doctors who face every facet of every problem in medicine. I am speaking, of course, of the American Medical Association.

I am pleased in making this report to tell you that the AMA is really in very good shape. It is financially sound and is the world's largest publisher of medical scientific literature. *The Journal of the AMA* is published in many foreign languages as are some of the specialty journals. The AMA has an aggressive investment program that is very carefully monitored by staff and the Board of Trustees. Real estate programs in Chicago and Washington account for reserves for cash flow and for future growth. These and other elements and a sound and well structured program allow membership dues to be kept at a reasonable level. Dues, however, account for only 44% of AMA's total income. And this is a cause for concern in a basic membership organization. The figure as of last Friday showed a grand total membership of 210,000 and, of course, that will rise through the rest of the year to about 250,000; this includes all categories.

What do you get for your dollar at AMA? Well for one thing, you get the opportunity to belong; to be a participant in the organization that speaks for you. Are you aware that AMA has a Washington office with its own building with a staff of 40 people? Do you know that every piece of health legislation is monitored and that appropriate comment is made and testimony presented on every one? One of the great successes came two weeks ago in the mandatory assignment issue. Proposed legislation would have required every doctor who works in a hospital to accept assignment from Medicare patients — the penalty being loss of hospital staff privileges. Unamerican? This bill would have passed the Congress had it not been for the American Medical Association. Doctors nationwide participated in a fly-in and in a contact blitz and Florida was in the foreground. AMA carefully orchestrated the debate in the House, and I saw a good bit of this.

The result was the resounding defeat of the bill on mandatory assignment. This is an accomplishment in which all of us can take great pride.

The most significant element in membership growth has been among students and residents with approximately 30,000 in each category. I would call now to the Florida Medical Association to beef-up its student and resident sections and to recruit actively these young people. They may even allow us another AMA Delegate. Certainly, these young participants are our future leaders.

There are two other categories of membership that I should emphasize. The first is that of women physicians. We very appropriately recognize and honor the ladies of the Auxiliary who do so much for the profession. We do not seem to give the same encouragement, however, to our female colleagues. These physicians in increasing numbers represent a great potential for membership. They should be urged not only to join our ranks, but to run for office in our local and state societies. They should be appointed to committees and councils. We must learn to listen to their unique set of problems, give them a voice, and appreciate them as fellow physicians.

Another group with unique problems is the foreign medical graduates — be they foreign or native born. Whether or not we have been part of the problem, certainly we must be part of the solution — and there are no easy solutions to this complicated situation. We should, however, give these, our present and future colleagues, a forum and a place. We should provide membership in our association and a helping hand. To this end the American Medical Association is re-creating its Committee on Foreign Medical Graduates and we plan to have some Floridians among that committee.

The AMA each year gives several awards and through the years a number of these have gone to Floridians. Since the last meeting of this House, the Benjamin Rush Award for Citizenship and Community Service has been conferred on Dr. Richard Hodes, a Past President of this Association.

One of the prestigious AMA awards is the Goldberger Award for Clinical Nutrition. This award will be presented next month at the Annual AMA House of Delegates. I am delighted to tell you that joining a distinguished list of recipients of the Goldberger Award is Dr. Louis Barness of the University of South Florida.

I must touch on the newest section in the AMA, the medical staff section. Last December, some 800 doctors from hospital medical staffs all over the country, including some of you, met and considered a wide variety of issues. These were reported to the AMA House of Delegates through a voting representative. I know some of you had gagged a bit on that yesterday, but let me tell you it is greatly significant. We are very proud of this new addition which brings the grass roots contingent even closer.

Finally, let us remind ourselves that our associations are what we make them. The AMA is that body which includes every state, every discipline, every specialty. It includes the medical schools and the medical staffs; the students and the residents; the VA and the Armed Forces. There is nothing else like it. The AMA needs you — you need the AMA.

Thank you.

At this time the Speaker asked that the members of Reference Committee No. III return to the podium to complete the presentation of their reference committee report.

Dr. Paul A. Flaten, Chairman, and his Committee came forward to present the remainder of the report of Reference Committee No. III, Finance and Administration, beginning with Recommendation No. C-5 of Report C of the Board of Governors.

RECOMMENDATION NO. C-5

THAT THE HOUSE OF DELEGATES APPROVE IN PRINCIPLE THAT THE FMA OFFER TO PROVIDE ADMINISTRATIVE SERVICES TO RECOGNIZED SPECIALTY GROUPS THROUGH LETTER AGREEMENT ON A COST REIMBURSEMENT BASIS.

Hospital Medical Staff Section: The Board approved the establishment of an Ad Hoc Committee of the Board to consider the feasibility of establishing a section or other appropriate mechanism for hospital medical staff input to the FMA.

The Ad Hoc Committee met on March 1, 1984 in Tampa, to assess alternatives for medical staff representation within the structure of the Florida Medical Association with careful emphasis on including county medical societies in the process. The Committee reviewed the medical staffs section within the structure of the American Medical Association and various models for hospital staff representation within other state medical associations. At the 1982 AMA Interim Meeting, Recommendation No. 4 was adopted as follows:

That the hospital medical staffs section shall be organized as an open assembly to which each hospital medical staff would be eligible to send one elected representative. All state and county medical societies are urged to work closely with medical staffs in their areas to facilitate participation in the section. A possible model would be a hospital medical staffs section at the annual meeting of each state House of Delegates and a Hospital Staff Liaison Committee in each county medical society, where appropriate.

It was reported that medical staffs sections have been created only by state medical associations already containing other sections. An attempt was made, therefore, to approach representation through a new Council on Hospital Medical Staffs which would be consistent with the existing organization of the Florida Medical Association. The Ad Hoc Committee identified two major goals which are:

- To provide a forum for hospital medical staffs to meet on a statewide basis to discuss common issues and concerns; and
- To provide an avenue for direct access into the policymaking body of the Florida Medical Association.

It is envisioned that the Council on Hospital Medical Staffs would meet at least twice per year. Nominees for the Council would come from county medical societies and this would provide impetus to each society to create its own Committee on Hospital Medical Staffs.

RECOMMENDATION NO. C-6

THAT THE HOUSE OF DELEGATES APPROVE AN AMENDMENT TO THE FMA BYLAWS TO PROVIDE FOR THE CREATION OF A COUNCIL ON HOSPITAL MEDICAL STAFFS WHOSE MEMBERSHIP WILL CONSIST OF TWO REPRESENTATIVES FROM EACH MEDICAL DISTRICT NOMINATED BY COUNTY MEDICAL SOCIETIES AND APPOINTED BY THE BOARD, PLUS A CHAIRMAN APPOINTED BY THE PRESIDENT; AND FURTHER, THAT THE COUNCIL ON MEDICAL STAFFS BE ALLOWED ONE VOTE IN THE FLORIDA MEDICAL ASSOCIATION HOUSE OF DELEGATES.

CHAPTER VIII
COUNCILS

Section 1. ORGANIZATION

Directly responsible to and reporting through the Executive Committee to the Board of Governors shall be the following councils:

1. Judicial;
2. Legislation;
3. Medical Economics;
4. Medical Services;
5. Scientific Activities;
6. Specialty Medicine;
7. **HOSPITAL MEDICAL STAFFS**

Section 3. DUTIES, FUNCTIONS, AND COMPOSITION

In general, the duties and functions of each council shall be:

7. THE COUNCIL ON HOSPITAL MEDICAL STAFFS SHALL CONSIST OF NINE MEMBERS, TWO FROM EACH OF THE FOUR MEDICAL DISTRICTS AND A CHAIRMAN APPOINTED BY THE PRESIDENT. THE DISTRICT MEMBERS SHALL BE APPOINTED BY THE BOARD OF GOVERNORS FROM NOMINATIONS RECEIVED FROM THE COMPONENT COUNTY MEDICAL SOCIETIES. EACH MEMBER SHALL SERVE A ONE-YEAR TERM AND MAY BE RENOMINATED AND REAPPOINTED. COUNCIL MEMBERS MUST BE MEMBERS IN GOOD STANDING OF THE FLORIDA MEDICAL ASSOCIATION. THE COUNCIL SHALL PROVIDE REPRESENTATION OF HOSPITAL MEDICAL STAFFS AND SHALL MAINTAIN LIAISON WITH AND SERVE IN AN ADVISORY CAPACITY TO HOSPITAL MEDICAL STAFFS AROUND THE STATE. IT SHALL PROVIDE AT LEAST TWICE ANNUALLY AN OPPORTUNITY FOR HOSPITAL MEDICAL STAFFS TO MEET WITH THE COUNCIL TO DISCUSS COMMON ISSUES AND CONCERNS. AT EACH SUCH MEETING ONE REPRESENTATIVE FROM EVERY HOSPITAL MEDICAL STAFF WITHIN THE STATE OF FLORIDA SHALL BE INVITED. ONE OF THOSE MEETINGS SHALL BE HELD IN CONJUNCTION WITH THE ANNUAL MEETING OF THE FLORIDA MEDICAL ASSOCIATION. THE COUNCIL SHALL STRIVE TO INCREASE ITS AWARENESS OF AND TO COMMUNICATE TO THE ASSOCIATION THE ISSUES THAT ARE AFFECTING PHYSICIANS AS MEMBERS OF HOSPITAL MEDICAL STAFFS. IT SHALL PROVIDE A VEHICLE TO IDENTIFY THE IMPLICATIONS OF FUTURE TRENDS AND THE ROLE OF PHYSICIANS INDIVIDUALLY AND AS MEMBERS OF MEDICAL STAFFS. IT SHALL DEVELOP AND MAINTAIN INFORMATION ON ISSUES OF COMMON CONCERN TO MEDICAL STAFFS AND DISTRIBUTE DATA ON SUCCESSFUL APPROACHES TO PROBLEMS. COUNCIL MEMBERS SHALL CONSIDER ALL MATTERS REFERRED TO IT BY THE HOUSE OF DELEGATES, BOARD OF GOVERNORS, EXECUTIVE COMMITTEE, OR PRESIDENT OF THE FLORIDA MEDICAL ASSOCIATION. IN ORDER TO ENSURE THAT HOSPITAL MEDICAL STAFFS ARE ADEQUATELY REPRESENTED, ONE MEMBER OF THE COUNCIL SHALL ALSO, BY VIRTUE OF APPOINTMENT TO THE COUNCIL, BECOME A VOTING DELEGATE TO THE HOUSE OF DELEGATES.

CHAPTER IV
HOUSE OF DELEGATES

Section 1. DESIGNATION AND COMPOSITION

~~The House of Delegates is the legislative and business body of the Association, and its members are the delegates officially elected by the component societies in accordance with the provisions of these Bylaws, and the Speaker and the Vice-Speaker of the House.~~



The annual Past President's Breakfast is always a highlight. Seated (left to right): James T. Cook, M.D., Marianna (1970); Henry J. Babers Jr., M.D., Gainesville (1969); Samuel M. Day, M.D., Jacksonville (1964); FMA Executive Vice President W. Harold Parham, D.H.A., Jacksonville; Jere W. Annis, M.D., Lakeland (1958); Floyd K. Hurt, M.D., Jacksonville (1971); Robert E. Windom, M.D., Sarasota (1982); and George S. Palmer, M.D., Tallahassee (1966). Standing (left to right): Thad Moseley, M.D., Jacksonville (1974); William J. Dean, M.D., St. Petersburg (1972); W. Dean Steward, M.D., Orlando (1967); Vernon B. Astler, M.D., Boynton Beach (1975); Joseph C. Von Thron, M.D., Cocoa Beach (1973); Jack A. MaCris, M.D., St. Petersburg (1976); T. Byron Thames, M.D., Orlando (1980); O. William Davenport, M.D., Miami (1978); Louis C. Murray, M.D., Orlando (1977); and H. Phillip Hampton, M.D., Tampa (1965).

THE HOUSE OF DELEGATES IS THE LEGISLATIVE AND BUSINESS BODY OF THE ASSOCIATION, AND ITS MEMBERS ARE THE DELEGATES OFFICIALLY ELECTED BY THE COMPONENT SOCIETIES IN ACCORDANCE WITH THE PROVISIONS OF THESE BYLAWS, ONE MEMBER OF THE HOSPITAL MEDICAL STAFFS COUNCIL APPOINTED IN ACCORDANCE WITH THE PROVISIONS OF THESE BYLAWS, AND SPEAKER AND VICE SPEAKER OF THE HOUSE.

~~deleted-language~~ **NEW LANGUAGE**

Optometric Drug Prescribing: The Board authorized continued financial assistance to the Florida Society of Ophthalmology in the legal procedures regarding prescribing of drugs by optometrists.

On March 22, 1984, the Florida Administrative Act Hearing Officer held the Board of Optometry rule invalid because there was no statutory authority for the use of prescription drugs by optometrists. The administrative hearing officer further stated that it is illegal for optometrists to use or prescribe drugs.

Organ Harvesting: The Board approved support of the Florida Society of Ophthalmology by participating with the Society as a friend of the court in a suit to protect the authority of medical examiners for the harvesting of organs including corneas, as currently provided under Florida laws. The Board recommended that the harvesting of organs be done in the most cosmetic manner possible and referred this issue to the Council on Legislation for appropriate action as may be indicated in the Legislature.

FMA Relative Value Studies: The Board approved a revision of the *1982 Relative Value Studies* and directed that the updated *RVS* be provided at no charge to those members of the FMA requesting copies prior to publication and that after the *RVS* is published that it be provided to members at cost.

Physician Fee Freeze: The Board reviewed the actions of the AMA Board of Trustees on February 23, 1984 calling on all physicians to voluntarily freeze their fees for one year and to continue to take into account the financial circumstances of each patient — especially the unemployed, the uninsured, and those under Medicare, and to accept reduced fees when warranted.

RECOMMENDATION NO. C-7

THAT THE HOUSE OF DELEGATES SUPPORT THE PROPOSAL OF THE AMERICAN MEDICAL ASSOCIATION TO REQUEST THAT ALL PHYSICIANS FREEZE THEIR FEES FOR ONE YEAR AND THAT THIS ACTION BE TAKEN WITH RECOGNITION OF THE DIFFICULTY THAT MANY PHYSICIANS IN FLORIDA MAY HAVE IN COMPLYING BECAUSE OF THE PROFESSIONAL LIABILITY CRISIS AND WITH THE FURTHER RECOGNITION THAT PAYMENT FOR PHYSICIANS' SERVICES IS NOT THE MAJOR CAUSE OF HEALTH CARE INFLATION BUT THAT THE MEDICAL COMMUNITY SHOULD TAKE A LEADERSHIP ROLE IN EFFORTS TO CONTROL THE INCREASE IN HEALTH CARE COSTS AND THAT VOLUNTARY ACTION IS THE MOST EFFECTIVE MEANS OF ACCOMPLISHING THIS GOAL.

FMA Auxiliary Public Relations Program: The Board enthusiastically approved the FMA Auxiliary public relations activities to be carried out during 1983-84 and authorized financial assistance to the Auxiliary for developing a video tape presentation to be used in conjunction with a statewide media day scheduled for October. The Board commended the Auxiliary for this innovative program which is aimed primarily at focusing attention on the positive contributions that the physician's family makes to the health and overall good of society.

AMA/GTE Telenet: The Board authorized the FMA to offer to component county medical societies the opportunity to participate in the AMA/GTE Telenet program by serving as distributors at the local (county) level for the GTE Telenet — Medical Information Network through contract with FMA. FMA currently serves as the statewide distributor for the network.

Appointments: The Board approved the nomination of Charles K. Donegan, M.D., as the AMA Delegate to serve on the Board of Governors. Norman M. Kenyon, M.D., was appointed as the optional member of the Executive Committee.

Appointed as advisory members of the Board of Governors were Vernon B. Astler, M.D., Florida Physicians' Insurance Reciprocal and Public Relations Officer; Eugene G. Peek Jr., M.D., Department of HRS; Robert N. Webster, M.D., State Board of Medical Examiners; and Mr. D. Scott Featherman, medical student member.

Gerold L. Schiebler, M.D., was appointed as an Assistant Editor of *The Journal of the Florida Medical Association, Inc.*, from the Board of Governors.

T. Byron Thames, M.D., was named Chairman of the Committee on Professional Liability. Edward R. Annis, M.D., was appointed Chairman of the FMA Speakers Bureau.

Charles K. Donegan, M.D., and Joseph C. Von Thron, M.D., were elected as Chairman and Vice Chairman, respectively, of Florida's AMA Delegates.

FMA Councils and Committees

JUDICIAL COUNCIL

Amendment to Medical Practice Act: The Board expressed support for an amendment to Florida's Medical Practice Act to remove the current restriction relating to membership on the State Board of Medical Examiners that prevents faculty members of medical schools from serving on the Board.

New County Medical Society Charters: The Board considered a report and recommendations of the Council regarding applications for new county medical society charters.

RECOMMENDATION NO. C-8

THAT THE HOUSE OF DELEGATES APPROVE GRANTING A CHARTER FROM THE FLORIDA MEDICAL ASSOCIATION TO THE PROPOSED BRADFORD COUNTY MEDICAL SOCIETY.

RECOMMENDATION NO. C-9

THAT THE HOUSE OF DELEGATES DISAPPROVE GRANTING A CHARTER FROM THE FLORIDA MEDICAL ASSOCIATION TO THE PROPOSED ST. JOHNS COUNTY MEDICAL SOCIETY.

COMMITTEE ON IMPAIRED PHYSICIANS

Impaired Physicians Program Funding/Medical Director: The Board enthusiastically approved the concept of a full-time medical director for the Impaired Physicians Program and determined that the FMA contribute an amount up to $120,000 for 1984 for the Program in order to allow for the employment of a full-time medical director. The Board further approved recommending to the House of Delegates that $10 annually per dues paying member be allocated from any further FMA dues increase for the Impaired Physicians Program.

Goals and Objectives: The Board approved the Goals and Objectives of the Committee on Impaired Physicians for 1983-84 including:

- Identifying and securing additional methods of funding for the Program and the employment of a full-time medical director;
- Provision of adequate benefits for treatment of chemical addiction included in the appropriate insurance programs sponsored by the FMA;
- Promotion and creation of impaired physicians committees in at least 10 additional FMA county medical societies;
- Training of additional physicians as qualified intervenors;
- Provide up-to-date scientific information concerning chemical addiction to members of the FMA; and
- Keep the medical profession in Florida advised of the status of the Impaired Physicians Program and new developments.

American Medical Society on Alcoholism: The Board approved the recommendation that the American Medical Society on Alcoholism be invited to join the Committee on Impaired Physicians as a co-sponsor for the Section on Chemical Dependency at the 1984 FMA Annual Meeting.

Impaired Physicians Funding: The Board authorized the Impaired Physicians Committee to request that other in-state professional groups using the FMA Impaired Physicians Program contribute $10 per dues paying member per year toward administration of the Program.

Voluntary Contributions: The Board approved an ongoing solicitation for voluntary contributions to the FMA Impaired Physicians Program Loan Fund to be conducted through *The Journal of the Florida Medical Association, Inc.*, and other FMA publications.

LIAISON COMMITTEE WITH ALLIED HEALTH GROUPS

Advanced Registered Nurse Practitioners: The Board requested that the Committee continue to monitor closely the development of rules by the Joint Committee of the State Board of Medical Examiners and Board of Nursing regarding additional acts to be performed by ARNPs and the number of ARNPs which may be supervised by one physician or dentist.

AD HOC COMMITTEE ON THE COST OF MEDICAL CARE

Statewide Business Coalition: The Board authorized the FMA to pursue the development of a statewide business coalition to serve as a liaison between the business and medical communities on an ongoing basis.

Meetings With Organized Business Leaders: The Board endorsed FMA representatives meeting with organized business leaders to discuss ways for dealing with health care cost containment and to seek their support for the Florida Medical Association's efforts in establishing a statewide peer review organization and the Association's tort reform efforts as mechanisms for containing health care costs.

FLORIDA PHYSICIANS' INSURANCE RECIPROCAL

The Chairman of the Board and Attorney-in-Fact/President of the Florida Physicians' Insurance Reciprocal presented to the Board of Governors a current status report and the year-end (1983) financial statements. The Board noted the adverse trend and the net operating loss of over $8 million by the Reciprocal due primarily to the frequency and severity of large claims. A detailed report on the FPIR is included in the *Delegates' Handbook*.

1983 House of Delegates Referrals

The Board reviewed the proceedings of the House of Delegates and items requiring additional study and/or action were referred to the appropriate councils and committees. Some matters required Board action only. Individual actions regarding the policies of the House of Delegates appear in the various council and committee reports as well as in this and other reports of the Board of Governors in the *Delegates' Handbook*.

SUBSTITUTE RESOLUTION 83-20
Liaison Committee to the Florida Physicians' Insurance Reciprocal

This resolution was adopted by the House of Delegates and referred to the President for appointment of this committee.

RESOLVED, That the Board of Governors establish a five-member standing committee entitled the Liaison Committee to the Florida Physicians' Insurance Reciprocal. The Committee shall be composed of five members recommended by the Council on Specialty Medicine but not necessarily members of the Council and approved by the Board of Governors. All members of the Liaison Committee to the Florida Physicians' Insurance Reciprocal shall be insured by the Florida Physicians' Insurance Reciprocal. This Committee shall be constituted for the purpose of enhancing member confidence in PIMCO and the Florida Physicians' Insurance Reciprocal. The Committee will hear members' complaints concerning PIMCO and the Reciprocal and will attempt mediation of these problems. The Committee may recommend policy to PIMCO and the Florida Physicians' Insurance Reciprocal. The Committee shall meet at least twice annually with the Board of Directors of PIMCO and the Florida Physicians' Insurance Reciprocal.

The Board approved the President's nominations for appointment of the following physicians to the Liaison Committee to the Florida Physicians' Insurance Reciprocal (FPIR):

Robert E. McCammon, M.D., Chairman
Obstetrics/Gynecology, Tampa
William W. Thompson, M.D.
Pediatric Allergy, Ft. Walton Beach
James F. Cooney, M.D.
Neurosurgery, West Palm Beach
H. Quillian Jones Jr., M.D.
General Surgery, Ft. Myers
Jimmie Dale Moore, M.D.
Anesthesiology, Orlando



Executive Vice President W. Harold Parham, D.H.A. and Executive Director Donald C. Jones.

A report on the activities of the Committee to date is included in the *Delegates' Handbook*.

RESOLUTION 83-13
FMA President's Compensation

This resolution introduced by the Broward County Medical Association was adopted by the House of Delegates.

RESOLVED, That the Board of Governors review the reimbursement policies for the President of the FMA to reflect adequate compensation for time away from his practice.

In compliance with the actions of the House, the Board determined that the FMA President be provided with annual compensation and that this be reviewed annually to ensure adequate compensation for time away from his practice.

Report F
Supplement to Report C
of the
Board of Governors

Report F, Supplement to Report C, of the Board of Governors, including Recommendation No. F-1 and Recommendation No. F-2, was adopted as presented.

Report F
Supplement to Report C
of the
Board of Governors
J. Lee Dockery, M.D., Chairman

JUDICIAL COUNCIL

In compliance with the FMA Bylaws, the Board of Governors has considered nominations for terms expiring on the Judicial Council in 1984.

RECOMMENDATION NO. F-1

THAT THE HOUSE OF DELEGATES APPROVE THE NOMINATION OF KENNETH C. KIEHL, M.D., OF SARASOTA, FOR ELECTION TO A FIVE-YEAR TERM ON THE JUDICIAL COUNCIL AS THE REPRESENTATIVE FOR DISTRICT B.

Committee on Membership and Discipline

In compliance with the FMA Bylaws, the Board of Governors considered nominations for terms expiring in 1984 on the Committee on Membership and Discipline.

RECOMMENDATION NO. F-2

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING NOMINATIONS FOR ELECTION TO THE COMMITTEE ON MEMBERSHIP AND DISCIPLINE FOR THE TERMS INDICATED.

DISTRICT 1:	**ROBERT C. PALMER, M.D. (88)**
DISTRICT 2:	**JAMES T. COOK JR., M.D. (88)**
DISTRICT 3:	**JOHN A. RUSH, M.D. (88)**
DISTRICT 4:	**RICHARD W. SNODGRASS, M.D. (88)**
DISTRICT 5:	**CLARENCE M. GILBERT, M.D. (88)**
DISTRICT 6:	**DAVID A. JOHNSON, M.D. (88)**
DISTRICT 7:	**WILLIAM B. HOPKINS, M.D. (88)**
DISTRICT 8:	**JOHN T. KARAPHILLIS, M.D. (88)**
DISTRICT 9:	**JOSEPH P. LEVINE, M.D. (88)**
DISTRICT 10:	**WILEY E. KOON, M.D. (88)**
DISTRICT 11:	**JOHN O. RAO, M.D. (88)**
DISTRICT 12:	**ROBERT BURGER, M.D. (88)**
DISTRICT 13:	**DAVID L. THOMAS, M.D. (88)**
DISTRICT 14:	**WILLIAM J. ROMANOS JR., M.D. (88)**
DISTRICT 15:	**WAYNE G. RISKIN, M.D. (88)**
DISTRICT 16:	**NESTER C. GUATY, M.D. (88)**
DISTRICT 17:	**RICHARD C. CLAY, M.D. (88)**
DISTRICT 18:	**JEROME BENSON, M.D. (88)**
DISTRICT 19:	**RUFUS K. BROADAWAY, M.D. (88)**

PROFESSIONAL LIABILITY

The Association is working diligently to implement the professional liability program unanimously adopted by the House of Delegates at the special Called Meeting on January 28, 1984:

- To seek to have placed on the ballot for the November General Election a proposed amendment to the Florida Constitution adding a new section to Article I of the Constitution to provide:

  In civil actions:

  a. No party can be found liable for payment of damages in excess of his/her percentage of liability;
  b. The Court shall grant a summary judgment on motion of any party when the Court finds no genuine dispute exists concerning the material facts of the case;
  c. Noneconomic damages such as pain and suffering, mental anguish, loss of consortium, and loss of capacity for enjoyment of life shall not be awarded in excess of $100,000 against any party.

- That the FMA maintain a legislative posture relative to tort reform and that any proposed legislation embody the same principles proposed to the public for constitutional revision including summary judgments, elimination or limitations on noneconomic damages and the elimination of joint and several liability.
- Each FMA active member will be required to pay a mandatory assessment of $300.00 for 1984, in addition to all current FMA dues and fees, to be utilized in implementing the professional liability program approved by the House of Delegates, and the FMA Board of Governors shall set an appropriate due date for payment of the assessment.
- Approved the continued study of the concept of the hospital admissions insurance proposal, "no fault concepts", and the problem of contingency fees.
- That the members of the House of Delegates individually assume responsibility for informing their constituents about the need to participate personally in educating the public about the professional liability problem.

The campaign to have the FMA tort reform proposal placed on the November election ballot has begun. The campaign is entitled, "Reason '84: Citizen's Rights in Civil Actions."

The Reason '84 Campaign Office was opened on Monday, April 16, and is located at 1000 Riverside Avenue, Suite 206, Jacksonville, Florida 32204. The phone number is (904) 355-3252. The key members of the Campaign staff have been retained by FMA Public Relations Consultant Mr. Roy Pfautch in accordance with previous authorization of the Board of Governors:

Mr. Sergio Bendixen, General Campaign Manager
Ms. Karen Kapler, Deputy Campaign Manager and Field Organizer
Mr. Kam Kuwata, Press Secretary
Ms. Frances Hightower, Administrative Assistant

The initial phase of the Campaign will be the signature petition drive obtaining the 300,000 signatures of Florida registered voters required to have the amendment qualify to be placed on the November 1984 General Election ballot. FMA President Dr. Dockery has asked all FMA and FMA Auxiliary members to help by obtaining as many signatures as possible. Patients, family, friends and business associates are part of a broad-based public signature campaign.

The $300.00 mandatory assessment was billed to all FMA regular active dues paying members on March 9, 1984, following the statewide membership Teleconference held on professional liability on March 8. The purpose of the Teleconference was to report to the grass roots membership the same information presented to the House of Delegates at its special Called Meeting. All associate and dues exempt members have also been offered the opportunity to participate in the assessment on a voluntary basis. As of the date of this report, 5,061 active dues paying members have paid the assessment which is due within 60 days (by May 9) for a total of $1,518,300. Voluntary payments have been recieved from 479 associate and dues exempt members for a total of $144,815. Total assessment income to date is $1,663,115.

In compliance with the House of Delegates actions, the Association has also continued efforts to bring about effective tort reform through the legislative process. Bills encompassing the same proposals as those included in the constitutional amendment have been introduced for consideration in the 1984 Legislative Session. Bills have been filed in the Senate (SB 835) and House (HB 1055) and report on the status of the FMA's tort reform proposal is included in the report of the Council on Legislation in the *Delegates' Handbook* (Reference Committee No. IV).

FMA-Sponsored Insurance Programs: The Board approved Loyalty Life Insurance Company and Old Line Insurance Company for the FMA-sponsored life insurance program and authorized PIMCO to enter into a general agent's agreement with both of these companies.

Blue Cross and Blue Shield PARS Plus Program: The Board received a report on the PARS Plus Program sponsored by Blue Cross and Blue Shield of Florida and directed that a careful study of the components of the Program be conducted in order that an appropriate FMA position can be developed as warranted.

1983 House of Delegates Referrals

RESOLUTION 83-3
Restoration of Coverage for Mental and Nervous Disorders
Dade County Medical Association

RESOLUTION 83-4
Coverage for Addictive Diseases
Dade County Medical Association

RESOLUTION 83-8
FMIT Psychiatric Benefits
Dade County Medical Association

The House of Delegates considered these three resolutions together because they dealt with a similar subject. The resolutions were not adopted but referred to the Board of Governors for review in consultation with representatives of the appropriate psychiatric groups for consideration of appropriate changes in coverage where reasonable, practical, and actuarially sound. Pursuant to the actions of the House of Delegates, the officers of the FMA and Trustees of the FMIT have met with representatives of the Florida Psychiatric Society and the South Florida Psychiatric Society to consider coverage for mental and nervous disorders under the FMIT program. The FMIT Trustees have also conducted indepth actuarial studies regarding the economic feasibility of increasing FMIT mental and nervous benefits to the same level as other conditions. As a result of this study, the FMIT Trustees wish to make the following observations:

1. Actuarial studies have determined that the impact of providing similar benefits for mental and nervous illnesses would result in an overall 10% increase in premiums. This would be in addition to the 10.75% increase in premium that has been approved by the FMA Board of Governors to become effective June 1, 1984 to insure the actuarial soundness of the FMIT program.
2. An extra 10% increase in premium over that projected for 84-85 would cause the FMIT to be noncompetitive in the marketplace and would pose serious jeopardy to the entire program.
3. The FMIT mental and nervous coverage is normally broader than most programs for similar type groups. FMIT is a large number of small groups and most of the coverages available to small groups for mental and nervous coverage is less than FMIT.
4. An American Psychiatric Association study of 300 insurance plans reveals 88% of the plans provided outpatient coverage for mental and nervous conditions on a reduced benefit level basis as compared to other physical disorders.
5. A federal report entitled "Cost Sharing and the Demand for Ambulatory and Mental Health Services" revealed that expansion of benefits for mental and nervous or a reduction in the patient's cost sharing essence increased the amounts of claims you will incur. The report indicated the majority of the health plans reviewed had some type of limitations on outpatient care and the limitation did lessen the utilization because of the higher cost sharing with the patient.
6. When FMIT did its initial study in August 1983, the American Psychiatric Association Group Coverage provided to its members had a limitation on the number of outpatient visits allowed of 50 outpatient visits per year.
7. The Texas Medical Association Plan which is similar to the FMIT program, provides a limitation of 50 outpatient visits in a calendar year, and overall lifetime limitation of $10,000 for all inpatient and outpatient treatment for mental and nervous services.
8. FMIT is a group of small groups and cannot be compared with the large single employer. The American Psychiatric Association study of the 300 insurance plans revealed that plans having lesser benefits for mental and nervous conditions compared to other disorders are most likely to incur with smaller group sizes and plans providing equal benefits for all services including mental and nervous are most likely to incur with large groups.
9. The FMIT offered the mental and nervous rider to all of the FMIT members on April 25, 1983, and received 16 applications. It is recognized the premium charge of $200 for a single contract and $300 for a family contract may have limited the number of applications, but the response was still small.

While it does not appear to be feasible to make changes in the coverage for mental and nervous disorders under the FMIT program at the present time, the FMIT Trustees will continue discussions with the appropriate psychiatric representatives to evaluate practical and actuarially sound coverage which might be implemented for mental and nervous disorders which does not pose any financial jeopardy to the program.

Report of Public Relations Officer

The Report of the Public Relations Officer was adopted as presented.

Public Relations

Vernon B. Astler, M.D., Public Relations Officer

The FMA House of Delegates' decision to pursue tort reform through the state constitutional amendment process will present new challenges to the Association's public relations program and all physicians and staff members associated with it.

Successful accomplishment of this goal at the polls in November will hinge on the complete cooperation of the entire FMA membership. Indeed, each FMA member should consider himself an FMA public relations representative first as petitions are circulated to garner the necessary number of signatures of registered voters to get the issue on the November 2 ballot, then as we attempt to convince the electorate of the necessity and wisdom of our program.

Each FMA member should commit himself to learn all he can about the tort reform amendment, discuss it with his patients and friends, and be responsive to requests by the leadership for assistance. Prior to the November election, many physicians will be asked to appear before civic clubs, retired groups, etc., to explain our problems in the liability field and the pressing need for the constitutional amendment. One can anticipate questions on health costs and doctor charges and should be prepared to respond in a truthful and positive manner.

A statewide teleconference was arranged for March 8, 1984, so that the comprehensive report on all aspects of the professional liability crisis that was presented at the special Called Meeting of the House of Delegates in January could be shared with the entire FMA membership.

In the coming months, in addition to working in the area of professional liability, the Communications Department staff will be assisting two FMA committees to develop public relations programs. The FMA Committee on Emergency Medical Services has secured Board of Governors approval for a program of education and public relations that will illustrate the significant role of emergency medical services in Florida's health care system. The program will be based on the Florida Medical Foundation's Emergency Medical Services Project and the five-year State Plan.

The Board also approved a public relations program to educate the community and the profession on the support services that are available for citizens, including the elderly, and to promote the concept of family health care for senior citizens.

Following are some of the highlights of FMA public relations program activities since the last Annual Meeting:

1. A two-hour Workshop on Media Relations was conducted as part of the FMA Leadership Conference in January. Speakers included two physicians who have had extensive experience with the media; a television station general manager; a metropolitan newspaper editor; and the medical writer. They discussed such aspects of media relations as interviews, responding to media inquiries, news conferences, letters to the editor and editorial visitations. The program was presented twice during the Leadership Conference.
2. *The FMA Public Relations Guide*, first published in 1976, was updated and revised as the Second Edition. Copies were available for distribution at the FMA Leadership Conference.
3. FMA Communications Department staff has been conducting a series of visits with medical writers to supplement the editorial board visitation program that was carried out during the spring of 1983 and before. Visitations have been conducted with writers for the *Gainesville Sun*, *Orlando Sentinel*, *Tampa Tribune*, and *St. Petersburg Times*, and additional visits will be conducted in the future. In addition, most of the correspondents comprising the Capital Press Corps in Tallahassee have been visited.
4. FMA continues to sponsor the Medical Journalism Awards Contest, and winners of the 1984 contest will be honored at the FMA Annual Meeting in May. This year, the contest rules, categories and procedures were revised and clarified. Also overhauled were the rules and categories for the Medical Speakers Awards Contest.
5. Assistance has been rendered to other FMA departments in the development of brochures and other projects. Examples include development of a pamphlet promoting the AMA and FMA sponsored GTE Medical Information Network (MINET); and brochures on Health Maintenance Organizations (HMOs), health care costs, and Workers' Compensation.
6. Weekly newspapers continue to use the Medical Message columns that are distributed twice a month. These popular columns feature timely health tips written for the lay public.
7. The *FMF Impaired Physicians Newsletter* is the latest addition to the family of FMA newsletters. It was launched in January and will be published quarterly (January, April, July and October) as part of *The Journal of the Florida Medical Association, Inc.* Other newsletters published from time to time include *Briefs*, *Graypaper*, *Legislative Bulletin* and *FLAMPAC newsletter*.

Liaison Committee to the Florida Physicians' Insurance Reciprocal

The Report of the Liaison Committee to the Florida Physicians' Insurance Reciprocal was adopted as presented.

Liaison Committee to the Florida Physicians' Insurance Reciprocal

Robert E. McCammon, M.D., Chairman

The Florida Medical Association House of Delegates at its meeting in May 1983 adopted Substitute Resolution 83-20 which provided:

RESOLVED, That the Board of Governors establish a five-member standing committee entitled the Liaison Committee to the Florida Physicians' Insurance Reciprocal. The Committee shall be composed of five physicians recommended by, but not necessarily members of, the Council on Specialty Medicine and approved by the Board of Governors. All members of the Liaison Committee to the Florida Physicians' Insurance Reciprocal shall be insured by the Florida Physicians' Insurance Reciprocal. This Committee shall be constituted for the purpose of enhancing member confidence in PIMCO and the Reciprocal and will attempt mediation of these problems. The Committee may recommend policy to PIMCO and the Florida Physicians' Insurance Reciprocal. The Committee shall meet at least twice annually with the Board of Directors of PIMCO and the Florida Physicians' Insurance Reciprocal.

On December 28, 1983 the Council on Specialty Medicine forwarded its recommendations to the Board of Governors for appointments to the Liaison Committee. The Board of Governors at its January 1984 meeting appointed Robert E. McCammon,

M.D., Obstetrics and Gynecology, Tampa; James F. Cooney, M.D., Neurosurgery, West Palm Beach; H. Quillian Jones Jr., M.D., General Surgeon, Ft. Myers; Jimmie Dale Moore, M.D., Anesthesiology, Orlando; and William W. Thompson, M.D., Pediatric Allergy, Ft. Walton Beach, to the Committee. FMA President, Dr. Dockery, subsequently named Robert E. McCammon, M.D., as Chairman.

The Committee held its first meeting on February 23, 1984 when it met in Tampa with the Board of Directors of the Florida Physicians' Insurance Reciprocal. The meeting served both as an organizational and as an informational session. The Committee members reviewed at length a wide variety of issues and concerns which the Committee members had heard expressed by members of FMA.

The Committee plans to hold a telephone conference meeting during the month of March and will also meet on April 11 with the PIMCO Board. After that meeting the Committee will prepare a more detailed supplemental report for presentation to the House of Delegates.

Supplemental Report of the Liaison Committee to the Florida Physicians' Insurance Reciprocal

Recommendation No. 1 of the Supplemental Report of the Liaison Committee to the Florida Physicians' Insurance Reciprocal was referred to the Board of Governors.

Recommendation No. 3 was adopted as presented.

A motion of the Reference Committee was carried to amend Recommendation No. 4, lines 3 and 4, to read ". . .present and former members of the Florida Physicians' Insurance Reciprocal. . .."

The Supplemental Report of the Liaison Committee to the Florida Physicians' Insurance Reciprocal was adopted as amended.

Supplemental Report of the Liaison Committee to the Florida Physicians' Insurance Reciprocal

Robert E. McCammon, M.D., Chairman

As set forth in its primary report, on February 23, 1984, the members of the Liaison Committee to the Florida Physicians' Insurance Reciprocal met with the Board of Directors of the Florida Physicians' Insurance Reciprocal. On April 11, 1984, the Committee met with the members of the Board of Directors of PIMCO to discuss concerns expressed by the membership relative to the management of the Florida Physicians' Insurance Reciprocal. The members of the Liaison Committee would like to express their highest commendations to the Board of Directors of PIMCO for the fine job they continue to do in managing the activities of our physician-sponsored insurance company and to the members of the Board of the Florida Physicians' Insurance Reciprocal for their time and diligence in the activities of the Reciprocal.

It is the feeling of the members of the Liaison Committee that the questions and concerns expressed by the membership regarding the Reciprocal and its management company, PIMCO, have resulted primarily from a breakdown in communications. Generally there exists a lack of understanding on the members' part of what happens regarding the legal aspects of a claim. Further, many are confused regarding the difference between PIMCO and the Reciprocal. The Liaison Committee investigated one member's complaint regarding the handling of a claim and found that the Reciprocal had failed to properly explain the claims process to the physician involved. Claims investigators have been made aware of the company policy in the area and the Committee believes the situation has been corrected.

It was noted that the membership of the Reciprocal today is largely comprised of initial subscribers. In recent years the number of new members and/or newly licensed physicians becoming members of the Reciprocal has been negligible and if the Reciprocal is to continue to serve its members, an effective program for increasing membership in the Reciprocal must be developed and implemented.

RECOMMENDATION NO. 1

(Not adopted — Referred to Board of Governors)

THAT THE BOARD OF THE FLORIDA PHYSICIANS' INSURANCE RECIPROCAL BE EXPANDED FROM THE EXISTING FIVE MEMBERS TO SEVEN MEMBERS TO INCLUDE TWO MEMBER AT-LARGE POSITIONS TO BE APPOINTED BY THE FMA BOARD OF GOVERNORS. THE MEMBER AT-LARGE POSITIONS ON THE RECIPROCAL BOARD SHALL HAVE STAGGERED THREE YEAR TERMS, SHALL BE ELIGIBLE FOR REAPPOINTMENT FOR ONE ADDITIONAL TERM ONLY, SHALL BE INSURED BY THE FLORIDA PHYSICIANS' INSURANCE RECIPROCAL AND SHALL NOT BE PAST PRESIDENTS OF THE FLORIDA MEDICAL ASSOCIATION. THESE TWO POSITIONS ARE CREATED FOR THE PURPOSE OF IMPROVING COMMUNICATIONS WITH THE MEMBERSHIP.

RECOMMENDATION NO. 2

THAT ADDED EMPHASIS BE MADE ON THE IMPORTANCE OF RECRUITING NEW MEMBERS AND ESPECIALLY NEWLY LICENSED PHYSICIANS IN FLORIDA TO THE FLORIDA PHYSICIANS' INSURANCE RECIPROCAL. EFFECTIVE MARKETING OF THE BENEFITS OF BELONGING TO THE FLORIDA PHYSICIANS' INSURANCE RECIPROCAL IN REGARDS TO NEWLY LICENSED PHYSICIANS IN FLORIDA SHOULD BEGIN PRIOR TO THEIR JOINING THEIR LOCAL COUNTY MEDICAL SOCIETY.

RECOMMENDATION NO. 3

THAT IN THE INTEREST OF ENHANCING MEMBER CONFIDENCE AND INCREASING COMMUNICATIONS WITH MEMBERS EMPHASIS BE PLACED ON DEVELOPING AND IMPROVING COMMUNICATIONS AMONG MEMBERS OF THE FLORIDA PHYSICIANS' INSURANCE RECIPROCAL BY IMPLEMENTING AN EFFECTIVE PUBLIC RELATIONS PROGRAM, INCLUDING A NEWSLETTER OR OTHER APPROPRIATE PUBLICATION TO THE MEMBERS INFORMING THEM OF THE ACTIVITIES OF THE FLORIDA PHYSICIANS' INSURANCE RECIPROCAL.

RECOMMENDATION NO. 4

THAT IN AN EFFORT TO LEARN OF ANY PROBLEMS AND CONCERNS WHICH THE COMMITTEE MAY NOT BE AWARE OF, A SURVEY BE MAILED TO THE PRESENT AND FORMER MEMBERS OF THE FLORIDA PHYSICIANS' INSURANCE RECIPROCAL AND THAT THE SURVEY INCLUDE, AMONG OTHER ITEMS, THE FOLLOWING SUBJECT AREAS: PROBLEMS OR SUGGESTIONS REGARDING MEMBER COMMUNICATIONS WITH PIMCO AND THE FLORIDA PHYSICIANS' INSURANCE RECIPROCAL; CONCERNS REGARDING MEMBERSHIP IN THE RECIPROCAL; SUGGESTIONS FOR IMPROVEMENT; AND OPINIONS REGARDING THE ESTABLISHMENT AND IMPLEMENTATION OF A FLAT FEE PREMIUM FOR PROFESSIONAL LIABILITY INSURANCE.

Liaison with Blue Cross and Blue Shield of Florida, Inc.

A motion of the Reference Committee was carried to amend Section 2, Introduction of the Par-Plus Plan, line 5, to delete the words ". . .of the lower" to read: "This reimbursement is set at the 90th percentile of the usual or customary charges."

The Report of the Liaison with Blue Cross and Blue Shield of Florida, Inc. was adopted as amended.

Liaison with Blue Cross and Blue Shield of Florida, Inc.

Frank C. Coleman, M.D., Chairman

As the FMA liaison representative to Blue Cross and Blue Shield of Florida, Inc., I have attended three meetings of the Blue Cross and Blue Shield Board during the past twelve months.

The following items of importance to the Florida Medical Association were discussed:

1. **Plans of Blue Cross/Blue Shield to expand its activities in developing and operating HMOs and PPOs:** (It is anticipated that they will have a sufficient number of these alternative health care delivery systems to be within reach of 60% of the population within five years.)

2. **Introduction of the Par-Plus Plan:** Under this plan, physicians in Florida will be asked to sign a new participating agreement. Those signing the agreement will be obligated to accept the Blue Shield reimbursement as full payment. This reimbursement is set at the 90th percentile of the lower of the usual or customary charges. The allowable charges are updated annually.

   This plan is currently being field-tested in Alachua and Marion counties.

   Reimbursement for services provided by non-participating physicians is sent to the patient.

Ad Hoc Committee on the Cost of Health Care

The Report of the Ad Hoc Committee on the Cost of Health Care was adopted as presented.

Ad Hoc Committee on the Cost of Health Care

Richard S. Hodes, M.D., Chairman

The Ad Hoc Committee on the Cost of Health Care, chaired by Richard S. Hodes, M.D., met twice during the Association year. The Committee reviewed the many causes for the increases in health care costs such as: inflation, population growth, increase in the number of elderly individuals, government regulations, technology, labor costs, and indigent care. The Committee noted the need for hospitals to move away from "cost shifting" and begin to determine the real cost of each hospital service while at the same time considering the revenue generated by each service.

It was apparent to the Committee that government is not going to appropriate funds through taxes to cover the cost of indigent care nor the unpaid costs of Medicare and Medicaid as long as a hidden "sick tax" levied on paying patients is being realized. In addition, the Committee felt that health care costs will not be greatly affected until there is control over demand, an issue which physicians and hospitals have little control.

Business leaders, like physicians, are not supportive of government intrusion or regulations. However, they tend to feel there is no alternative to government regulations unless the medical profession is willing to help curb the rising costs of health care. The Committee recommended that the Florida Medical Association pursue the development of a statewide business coalition to serve as a liaison between the business and medical communities. Such a forum could be used to consider the need for changes in health insurance coverage, the effective use of outpatient services, ways to properly use the health care system and the importance of developing and maintaining a health lifestyle. Plans are underway to develop such a coalition and to have the President of the Florida Medical Association meet with business leaders from around the state so that a meaningful and ongoing dialogue is established to discuss the major health concerns of the business community and to offset the need for further government regulations.

Plans have been developed with Associated Industries of Florida to hold a meeting on March 27, 1984 between business leaders, chief executive officers of Humana and the Hospital Corporation of America, and representatives of the Florida Medical Association to discuss health care cost containment. One of the issues that Associated Industries would like to explore is the possibility of having business coalitions provide profile summaries of physicians' fees and information regarding hospital cost containment.

The Committee, through its Chairman, has monitored the development of cost containment legislation and provided input into the legislative development process as a means of balancing reason with emotional and political motivation.

Committee on Membership Development

The Report of the Committee on Membership Development was adopted as presented.

Committee on Membership Development

Luis M. Perez, M.D., Chairman

The Committee on Membership Development has been actively engaged during the past year in a number of projects aimed at increasing membership in both the Florida Medical Association and the American Medical Association.

In many of these projects, the Committee has worked closely with the AMA Department of Membership Development. Attention has been focused on increasing medical student membership as well as residents and practicing physicians.

At the end of 1983, FMA's total membership in all categories stood at 14,477, an increase of 2.3% over the previous year-end figure. The fact that only 62 of the state's 1,243 medical students are members indicates that much work remains to be done in that area.

Also at the end of last year, Florida was credited with 10,471 AMA members, a slight increase over 1982. This was sufficient for FMA to retain 11 seats in the AMA House of Delegates.

Following is a summary of the various approaches the Committee has been pursuing since the last Annual Meeting.

1. **Membership Solicitation Letters:** In the fall of 1983, a membership solicitation campaign was conducted by mail in cooperation with the AMA. More than 11,000 letters were sent to the following categories: FMA members who had paid 1982 AMA dues but had not renewed in 1983; FMA members who were not AMA members in either 1982 or 1983; non-FMA members in Florida who paid AMA dues direct in 1982 but had not paid for 1983; medical students and interns and residents who had joined AMA direct, but had not joined FMA or a county medical society; and all categories of students, residents and regular members who paid dues to AMA direct again in 1983, but were not FMA members.

   Another mailing is planned during the first or second quarter of 1984.
2. **Medical Students:** On January 10, 1984, your Chairman had the distinct privilege of attending a luncheon meeting with class officers of the University of Florida College of Medicine. Remarks about the advantages of becoming affiliated with organized medicine prompted many good questions from the class leaders.

   The University of Florida meeting followed a 1983 meeting of the Chairman with students at the University of South Florida College of Medicine. As this report was prepared, plans were being made for the Chairman to meet with students, residents and faculty at the University of Miami School of Medicine.

   The Committee on Membership Development has under consideration a proposal that the Committee, on an annual basis, request time on the freshman orientation program at the State's three medical schools for the purpose of explaining the advantages of student membership in the county medical societies, the FMA and the AMA.
3. **Physician Mobility Report:** The AMA is now supplying the Committee, on a weekly basis, a physician mobility report that shows recent physician movements into the state and into specific Florida counties. The Committee is developing a special recruitment program that will focus on this group of physicians and make contact with them as soon as possible after their arrival in Florida. The mobility report has been listing physician arrivals in Florida at a rate of 80 to 90 a month.
4. **AMA Exhibit:** The Committee ordered and displayed an AMA membership promotion exhibit at the FMA Leadership Conference in Jacksonville, January 27-29. The same exhibit will be displayed at the FMA Annual Meeting in May. In addition "AMA Member" stickers were affixed to physicians' badges at the Leadership Conference. "AMA Member" badge streamers will be used at the Annual Meeting.
5. **Florida State Medical Association:** The Dade County Medical Association has begun targeting members of the Florida State Medical Association, a predominantly black group, for membership recruitment. The Committee proposed to follow suit at the state level. The approach would be to encourage these physicians to be members of both the FSMA and the FMA.

   As an initial step, your Committee recommended to the Board of Governors in January that the FSMA be invited to send an observer to future FMA Annual Meetings, and that the privilege of the floor at the House of Delegates' sessions be extended to this individual.
6. **Specialty Groups:** The Committee is planning to launch cooperative membership recruitment efforts with some of the FMA-recognized state specialty groups. The proposal has been referred to the Council on Specialty Medicine, and it is hoped that several specialty groups will want to participate. A list of physicians who are not members of the FMA or the appropriate state specialty group will be compiled. Joint FMA-specialty group recruitment letters will be sent to these individuals.
7. **Journal Advertisements:** The AMA has prepared a new packet of membership promotion advertisements. Editors of *The Journal of the Florida Medical Association, Inc.*, have been most cooperative in running these ads from time to time.

FMA Speakers Bureau

The Report of the FMA Speakers Bureau was adopted as presented.

FMA Speakers Bureau

Edward R. Annis, M.D., Chairman

Your elected officers and committee chairmen were faced with a multitude of challenging problems as legislative enactments have stimulated revolutionary changes in how health care is to be delivered.

Federal deficit spending has continued the inflationary spiral which contributes more than 50% to increasing health care costs. Similarly government regulations at all levels have demanded more personnel and paperwork toward an additional 25% of costs over which the profession has no control. Because too few doctors and most of the general public are unaware of these major contributing factors to health costs, it has demanded a continuing effort of the educational process. The profession must be informed and the public ultimately educated to recognize that high quality care will continue to carry a high price tag in a nation of increasing population, increasing longevity and veritable explosion of technological advancements. Only an informed public can put obstacles in the way of uninformed and imprudent legislative mandates which would slow the rate of progress in our ability to cope with medical ills.

Legislation producing Diagnostic Related Groups (DRGs) for hospitals and threatening the same for physicians coincided with a government-financed targeted campaign to enroll the elderly of Florida into various Health Maintenance Organizations (HMOs). Meanwhile, employers, faced with cost shifts because of government underfunding of its responsibilities, have looked favorably toward Preferred Provider Organizations (PPOs), Exclusive Provider Organizations (EPOs), Individual Practice Associations (IPAs), and expected Peer Review Organizations (PROs) to slow the rate of increase in their health care costs for employees. Your elected leadership is aware of the frustrations attendant to these many problems and continues combined efforts toward their better understanding and reasonable solutions.

Failure to obtain tort reform at the legislative level and with truly unanimous support of your elected delegates, we are in the process of expanding a statewide appeal which will demand the assistance of all to inform our patients, the citizens of Florida, that it is their health care which is in potential jeopardy, while it is their pocketbook which must ultimately provide the costs of uncontrolled and escalating awards from juries ignorant of the complexities of medical practice.

All physicians are encouraged to read and keep current with all of these problems from information provided, and to share their views and recommendations with the ultimate decision makers who are their patients.



FMA's delegation to the American Medical Association prepared itself to attend the upcoming June AMA Annual Meeting in Chicago. Seated (left to right), Samuel M. Day, M.D., Jacksonville; Richard G. Connar, M.D., Tampa; Luis M. Perez, M.D., Sanford; Charles K. Donegan, M.D., St. Petersburg; Joseph C. Von Thron, M.D., Cocoa Beach; Frank C. Coleman, M.D., Tampa; Robert E. Windom, M.D., Sarasota; and Burns A. Dobbins Jr., M.D., Ft. Lauderdale. Standing (left to right): Arthur L. Eberly Jr., M.D., Lighthouse Point; Charles J. Kahn, M.D., Pensacola; James B. Perry, M.D., Ft. Lauderdale; William B. Deal, M.D., Gainesville; Rufus K. Broadaway, M.D., Miami; O. William Davenport, M.D., Miami; Eugene G. Peek Jr., M.D., Ocala; Dick L. Van Eldik, M.D., Lake Worth; and James W. Walker, M.D, Jacksonville.

Florida AMA Delegates

The Report of the Florida AMA Delegates was adopted as presented.

AMA Delegates

Charles K. Donegan, M.D., Chairman

It has indeed been a pleasure for me to serve as Chairman of your Florida AMA Delegates during the past year, ably assisted by our Vice Chairman, Joseph C. Von Thron, M.D.

The effectiveness and influence of our delegation at the national level is due to the time and effort given freely by your delegates and alternate delegates. A great deal of appreciation goes to:

T. Byron Thames, M.D., Delegate
Samuel M. Day, M.D., Delegate
Burns A. Dobbins Jr., M.D., Delegate
Richard G. Connar, M.D., Delegate
Charles J. Kahn, M.D., Delegate
Joseph C. Von Thron, M.D., Delegate
Louis C. Murray, M.D., Delegate
Robert E. Windom, M.D., Delegate
Luis M. Perez, M.D., Delegate
Sanford A. Mullen, M.D., Delegate
Vincent P. Corso, M.D., Alternate
James B. Perry, M.D., Alternate
Frank C. Coleman, M.D., Alternate
Eugene G. Peek Jr., M.D., Alternate
Vernon B. Astler, M.D., Alternate
O. William Davenport, M.D., Alternate
James W. Walker, M.D., Alternate
Joseph T. Ostroski, M.D., Alternate
William B. Deal, M.D., Alternate
Arthur L. Eberly Jr., M.D., Alternate
Dick L. Van Eldik, M.D., Alternate

We are pleased to announce that present at our caucuses were the delegates from Puerto Rico, Fernando J. Cabrera, M.D., and Emilio Arc, M.D.; the delegates from the Virgin Islands, Felix Pitterson, M.D., and Howard E. Hill, M.D.; and the AMA delegate from Guam, Leon L. Concepcion, M.D.

In addition to our delegation we were joined by many county medical society representatives and representatives from Florida to the Hospital Medical Staff Section.

The AMA House was faced with another year filled with a broad range of issues. The following is a summary of major actions taken by the House and of the activities of our Florida delegation during the Annual Meeting, June 19-23 and the Interim Meeting, December 4-7. The activities of your delegates have been reported to the FMA Board of Governors and the FMA membership through various Association publications.

1. **Candidates for Elective Office:** Your delegation is pleased to report the election of FMA President J. Lee Dockery, M.D., to the Council on Medical Education. Rufus K. Broadaway, M.D., was named Chairman of the Education and Research Foundation. Dr. Warren Lindau was a candidate for election to the Council on Scientific Affairs, but unfortunately was unsuccessful in this bid; however, his efforts were conducted in a creditable manner and reflected well on Florida.

   The Delegation would like to express its appreciation to all those who attended the Annual Meeting and particularly the FMA Auxiliary for its support and assistance with the campaign activities.
2. **Southeastern Delegation:** Your delegation was again active in the Southeastern Delegation which is composed of the following states:

Alabama	Maryland
Delaware	Mississippi
District of Columbia	North Carolina
Florida	South Carolina
Georgia	Virginia
Louisiana	

Activities included a breakfast caucus on Sunday morning, at which time major items of business to be addressed by the House were discussed, and a reception sponsored by your delegation (ably assisted by the FMA Auxiliary) on Monday evening.

3. **Benjamin Rush Award for Citizenship and Community Service:** Your delegation was very proud when Richard S. Hodes, M.D., shared with Samuel R. Sherman, M.D., a San Francisco surgeon, the Benjamin Rush Award for Citizenship and Community Service. Dr. Hodes was honored for his leadership role in state and national legislative activities including his accomplishments as a member of the Florida Legislature from 1966 to 1982; his term on the President's Advisory Commission on Intergovernmental Relations; and his service as Director of the Education Institute of Leadership in Washington, D.C.
4. **Resolutions:** The Florida delegation introduced two resolutions at the Annual Meeting of the AMA. Resolution 108 — Physician Exemption from Medical School Standards and Performance Evaluation Requirements — recommended to state medical licensing boards that foreign medical graduates licensed in the United States not be denied endorsement of their licenses or admission to re-examination solely because documents cannot be produced confirming that their medical schools meet equivalent standards. Resolution 108 was adopted as amended by Reference Committee C:

> RESOLVED, That the American Medical Association recommends to medical licensing boards that those physicians who are foreign medical graduates currently duly licensed by any licensing jurisdiction in the United States should not be denied endorsement of their licenses, or denied admission to re-examination when this is required by law, solely because they are unable to provide documentation to graduation from a school meeting "equivalent standards and performance evaluation requirements" to those of programs accredited by the Liaison Committee on Medical Education. It is recommended that licensing boards, in reviewing application for licensure endorsement, take into account a physician's ethical standards and his or her having practiced medicine of an acceptable quality.

The House also adopted the Florida Delegation-sponsored Resolution 90 which requested AMA to support and encourage the issuance of a commemorative postage stamp in honor of John Gorrie, M.D., inventor of artificial ice making and modern refrigeration.

The Florida Delegation introduced two additional Resolutions at the Interim Meeting. Resolution 19, which was defeated, recommended that the AMA work to promote the use of Patient Medication Instruction Sheets by pharmacists to increase the availability of drug use information for the public.

Resolution 20 asked that the AMA notify the management of E.R. Squibb and Sons, Inc., of its strong objection to the advertising campaign on "Opium" perfume; and that the AMA express strong objection to the management of Pippo, Inc., of the "Stash" advertising campaign; House of Dinard, Inc., of the "Sinsemalla" advertising campaign; and Cocaine International of the "Cocaine" advertising campaign. Resolution 20 was passed by the AMA House of Delegates.

It is with a deep sense of pride that your Delegation announces the passing of another resolution, the AMA Resolution of Commendation for FMA Executive Vice President, W. Harold Parham, D.H.A., thanking him for thirty-five years of devoted service to organized medicine.

Other AMA House Actions of Major Importance:

The following is a summary of other major actions taken by the AMA House of Delegates:

1. **Additions to the AMA Board of Trustees:** The Delegates approved increasing the size of the AMA Board of Trustees to provide for a resident physician member. The resident would be elected by the House of Delegates for no more than three terms of two years each. A non-voting medical student position on the AMA Board was also approved.
2. **Hospital Staff Involvement in DRGs:** It was decided that the AMA promote input by hospital medical staffs into the Diagnostic Related Groups (DRGs) process to ensure that quality of care is not compromised, in support of the concept that the individual hospital staff's responsibility is to ensure appropriate quality of care for patients. The House also instructed the AMA Board of Trustees to pursue a program of education and assistance for the membership covering DRGs.
3. **Public Education Program for use by Constituent Societies:** The House called for a model public education program for use by constituent societies informing the public of the potential threat to the quality of medical care from congressional proposals such as the Tax Equity and Fiscal Responsibility Act and prospective payment systems.
4. **Cost Reimbursement of Hospitals:** A resolution was passed urging governmental agencies responsible for reimbursing hospitals under Medicare and Medicaid to pay their fair share of the cost of hospital care based on full reimbursement for expenditures in a beneficiary's behalf regardless of whether the system is based on prospective rate setting or cost reimbursement.
5. **Equity of Reimbursement:** The House voted to urge the Department of Health and Human Services to implement more aggressively the existing provisions in federal legislation calling for equity of reimbursement between services provided by hospitals on an outpatient basis and similar services in physicians' offices.
6. **Federal Trade Commission:** The Board of Trustees was instructed to give the highest priority to legislation regarding the Federal Trade Commission's jurisdiction over professionals.
7. **Definition of "Physician":** A new definition of "physician", including Doctors of Osteopathy, was adopted as follows:

> A physician is a person who has been admitted to a medical school or a school of osteopathic medicine which school is approved by his or her state licensing board and has successfully completed the prescribed course of studies in medicine or osteopathic medicine and has acquired the requisite qualifications to be legally licensed to practice medicine or osteopathic medicine.
>
> The House also requested that AMA initiate and support legislation to amend appropriate sections of the Social Security Act to limit the use of the term "physician" to describe only Doctors of Medicine or osteopathic medicine, not only in the art itself, but also in regulation promulgation thereunder, without changing the current level of covered services provided by Medicare.

8. **Accreditation of Hospitals:** The AMA Board of Trustees was commended for its responsible consideration of the difficult issues confronting the Joint Commission on Accreditation

of Hospitals. The following principles were affirmed as the basis for any revision of the Medical Staff Section of the *Accreditation Manual for Hospitals:*

a. Continue to use the term "Medical Staff" in the title of the chapter and throughout the *Manual.*
b. Delete any specific reference to limited licensed practitioners now contained in the Medical Staff chapter of the 1983 *Accreditation Manual for Hospitals.* This does not preclude such practitioners from having hospital privileges consonant with their training, experience and current competence if approved by the normal credentialing process.
c. Provide consideration of qualified limited licensed practitioners in accordance with state law when approved by the executive committee of the medical staff, by the governing board and, when their services are appropriate to the goals and missions of that hospital, taking into account the training experience and current clinical competence of the practitioners.
d. Provide that the executive committee of the medical staff is composed of members selected by the medical staff, or appointed in accordance with the hospital bylaws. All members of the active medical staff, as defined in the Medical Staff Bylaws, are eligible for membership on the executive committee and a majority of the executive committee members must be fully licensed physician members (Doctors of Medicine or Doctors of Osteopathy) of the active medical staff in the hospital.
e. Assure that the medical care of all patients remains under the supervision and direction of qualified, fully licensed physicians (Doctors of Medicine or Doctors of Osteopathy).
f. Assure that the continued high quality of care, credentialing of physicians and other licensed practitioners, and effective quality assurance programs remain under the supervision and direction of fully licensed physicians.

The House called on the AMA Board of Trustees to direct its Commissioners to the Joint Commission on Accreditation of Hospitals to request a delay in final approval to any revisions to the Medical Staff chapter of the *Accreditation Manual for Hospitals* until after soliciting and considering comments from the AMA House of Delegates, medical societies, hospital medical staffs, hospitals and medical specialty organizations.

9. **Hospital Medical Staff Section:** It was decided that every state medical association should be encouraged to establish a statewide hospital medical staff section.
10. **Substitution of Drugs by Pharmacists:** The House asked the AMA to vigorously oppose any concept of therapeutic substitution of drugs by pharmacists, and asked medical societies to oppose legislation that would authorize pharmacists to dispense independently substitutes to a physician's prescription.
11. **Methaqualene:** The House adopted Report B of the Council on Scientific Affairs stating that the high order of abuse potential and high incidence of dependence risk, combined with the availability of any hypnotics of equal efficiency, argue against prescribing methaqualene except in patients with porphysia.
12. **Chelation Therapy for Atherosclerosis:** Chelation therapy was declared by the House an experimental process without proven efficacy. The Council on Scientific Affairs was asked to research the treatment.
13. **AIDS Advisories:** The AMA was asked to develop advisories for physicians which will assist them in responding to Acquired Immune Deficiency Syndrome (AIDS) by giving practical and medically sound advice to all individuals who may be at risk for contracting this condition, and to encourage research aimed at eliminating the occurrence of this syndrome.
14. **1984 Dues Increase:** A $15.00 increase in regular dues was approved for 1984. Other dues categories would be increased proportionally, except physicians in residency training and medical student dues. These two categories will have an increase of $5.00.
15. **Invitations to other Professional Societies:** The House decided to invite the American Osteopathic Association and the National Medical Association to send official observers to meetings of the AMA House of Delegates, with privileges of the floor by invitation.
16. **Tax Equity and Fiscal Responsibility Act (TEFRA):** The House reaffirmed that the AMA will continue to give a high priority to prompt withdrawal of regulations to implement Section 108 of TEFRA, and until such withdrawal, continue its opposition to inappropriate elements of these regulations, including arbitrary definitions of the practice of medicine and the limits on medical consultations, through appropriate actions in the legislative, executive and judicial areas. Repeal of the section that could deny a fee for assistant surgeons at teaching hospitals was also urged. The House also called for the provisions of the law relating to utilization and quality of medical care be extended to all non-military institutions.
17. **Boxing:** The House has called upon the AMA to publicize the deleterious effects of boxing on the health of the participants. Along these same lines, the AMA was asked to encourage the elimination of boxing from amateur scholastic, inter-collegiate and governmental athletic programs as detrimental to the participants' health. Also, the House asked the AMA to develop model legislation seeking to curtail the utilization of boxing as a public spectacle.
18. **Insanity Defense:** The House called for a narrowing of the use of the insanity defense in criminal trials and a replacement of the conventional insanity defense with statutes that would permit a defendant to be acquitted on insanity grounds only if the mental disease prevented the individual from committing the criminal act with the requisite state of mind, or mens rea.
19. **PPOs:** The House continued to oppose expansion of prospective pricing systems until the systems have been adequately evaluated with respect to their impact on quality, cost and access to medical care.
20. **Reimbursement Systems:** The concept that any reimbursement system for physicians' services be independent of reimbursement systems for other providers of health care was endorsed.
21. **Medicare Waivers:** The House cautioned individual states to proceed carefully in designing reimbursement systems for the express purpose of obtaining a Medicare waiver to opt out the federal DRG system. Medical societies in states that begin to develop cost control programs were urged to adopt workable strategies to help these systems.
22. **Medical Liability and DRGs:** The House referred to the AMA Board of Trustees for further study resolutions calling for a study of the medical liability implications associated with the implementation of the DRG system and the possibility of developing a pilot program for payment of both physicians and hospital components of care under a DRG system.
23. **Peer Review and Antitrust Laws:** The House called for exemption from antitrust laws for medical peer review activities requested by insurance companies.
24. **Development of Risk Management Strategies:** The House called for further study of a request that the AMA's Committee on Professional Liability develop legislative and risk

management strategies to help alleviate the health care professional liability crisis.

25. **Medicare Coverage for Home Care Services:** The AMA was asked to encourage Congress and the Health Care Financing Administration to provide the same Medicare coverage for home care services furnished by office-based physicians and their employees as those permitted for home health agencies services.

26. **Impairment:** Medical societies were encouraged to involve medical students and residents in activities to prevent and identify impairment.

27. **Food and Drug Administration:** The House referred to the Board a resolution encouraging Congress to require the Food and Drug Administration to expedite its evaluation and approval processes for technology and drugs to avoid delays to patients of the benefits of technology and drugs that have been tested by use.

28. **Hospital Records:** The House affirmed the responsibility of the attending physician to specify all diagnoses and procedures in the hospital record.

29. **Physician/Patient Relationship:** A resolution was referred that opposed any attempt by government to require change in physician/patient relationship.

30. **Risk-Sharing Arrangements:** The House asked the Judicial Council to study the ethical implications of risk-sharing arrangements between hospitals and their medical staffs under prospective pricing systems.

31. **JCAH — Standards for Hospital Medical Staffs:** The House of Delegates adopted an amendment to the Report of Reference Committee D regarding the policy of the AMA for standards for hospital medical staff privileges as follows:

> RESOLVED, That it be the policy of the American Medical Association that the hospital admitting privilege be granted in accordance with state law and in accordance with the criteria for standards of medical care established by the individual hospital medical staff; and be it further
>
> RESOLVED, That this policy be transmitted to the Joint Commission on Accreditation of Hospitals.

On December 10, 1983, the JCAH Board of Commissioners approved final revisions in the Medical Staff Chapter of the *Accreditation Manual for Hospitals*, including this insertion:

> Individuals granted the privilege to admit patients to inpatient services are members of the medical staff. INDIVIDUALS ARE GRANTED THE PRIVILEGE TO ADMIT PATIENTS TO INPATIENT SERVICES IN ACCORDANCE WITH STATE LAW AND CRITERIA FOR STANDARDS OF MEDICAL CARE ESTABLISHED BY THE INDIVIDUAL MEDICAL STAFF. When nonphysician members of the medical staff are granted privileges to admit such patients, provision is made for prompt medical evaluation by a qualified physician for all such patients. This requirement for prompt medical evaluation by a qualified physician does not apply to qualified oral surgeons who have been granted the clinical privileges to perform a history and physical examination.

32. **Other Actions:** The House of Delegates —

- — Called for the AMA to vigorously oppose any concept of therapeutic substitution of drugs by pharmacists.
- — Requested the Council on Scientific Affairs update its 1981 report on dioxin and the AMA institute a public information campaign to transmit accurate information on dioxin.
- — Directed the Board of Trustees to study the problem of financial assistance for medical students.
- — Directed the AMA to inform the public that any person considering participation in a weight loss program offered by a weight loss clinic should first consult his regular attending physician, or another independent physician, for a physical exam and an objective professional evaluation of the proposed weight loss program as it relates to the individual's physical condition.
- — Requested that the AMA continue to work towards a smoke-free society by the year 2000.
- — Approved support for The Injury Prevention Program (TIPP) of the American Academy of Pediatrics by publicizing joint efforts in accident and injury prevention.
- — Adopted a Judicial Council report enumerating grave ethical, legal, and psychological risks of a woman being paid to bear a child for another.
- — Reaffirmed public funding for abortion services.
- — Urged "Good Samaritan" legislative relief for in-flight medical emergency care.
- — Opposed a federal role in decision making about the care of severely ill newborns.
- — Adopted with commendation a board report summarizing a study on the direct and indirect costs of professional liability.
- — Directed the AMA to promote the reduction in deaths and injuries from drunk driving by 50% during the next five years and by an additional 25% during the following years.
- — Directed the AMA to develop model state legislation establishing insurance pools for high-risk individuals denied health insurance under traditional plans.
- — Approved a physician's guide to asbestos-related disease.
- — Adopted a report recommending that physicians stress the importance of exercise for older patients, take an active interest in their patients' exercise habits, and encourage all of their patients to establish an exercise program as a lifetime commitment in preparation for their later years.
- — Urged support of counseling and intervention to increase enrollment, retention, and graduation of minority medical students.
- — Opposed the sale of non-renewable, transplantable organs for profit and directed the AMA to continue monitoring legislation that is now being considered in Congress regarding the sale of human organs.
- — Called for continued monitoring of legislation to determine responsibility for asbestos-related illnesses and other occupation-related illnesses.

Judicial Council

The Reference Committee extended its highest commendations to Dr. James A. Winslow Jr., Chairman, for the excellent job he has done on behalf of his colleagues during his years of service on the Judicial Council.

The Report of the Judicial Council was adopted as presented.

Judicial Council

James A. Winslow Jr., M.D., Chairman

The 1984 Annual Report of the Judicial Council will summarize the major areas of activity that occupied the Council's time since the last Annual Meeting of the Florida Medical Association held in May of 1984. The Council's duties and functions and composition are specifically prescribed in Paragraph 8, Section 3 of the Florida Medical Association, Inc., Bylaws.

It is the function of the Judicial Council to direct and supervise the activities of the Association which pertain to questions of medical ethics, dissention, and disputes referred to the Association for investigation and adjudication, complaints by patients against members of the Association, and questions of membership and disciplinary action. The Judicial Council is also responsible for considering and recommending to the Board of Governors charters for county medical societies. The Bylaws of the Florida Medical Association further provide that the component county medical society shall be the basic unit for censuring, suspending, or otherwise disciplining its members. Any member subject to such action has a right to appeal to the Judicial Council in the manner prescribed in the Bylaws. Moreover, the Council is called on from time to time to review component county medical societies activities in respect to the policies adopted by the Florida Medical Association House of Delegates which are binding upon the component county medical societies and their members.

The Council receives, pursuant to this jurisdiction, numerous requests for opinions, requests for advice on Bylaw changes, etc.

Since the last Annual Meeting of the Association, the Council has met on the following occasions: May 4, 1983; November 19, 1983; and February 25, 1984. The current membership of the Council is as follows: James A. Winslow Jr., M.D., Chairman, of Tampa; Joseph H. Davis, M.D., of Miami; O. Frank Agee, M.D., of Gainesville; Robert J. Brennan, M.D., of Ft. Lauderdale; and Maurice H. Laszlo, M.D., of North Miami Beach. The Council has been staffed by Mr. John E. Thrasher, FMA Legal Counsel.

The Council's activities are summarized under the following headings:

Grievances

During the last year, the Council has continued to handle routine grievances that have been presented to it, pursuant to the Bylaws of this Association. The Council maintained its procedures of allowing county medical societies to resolve these local grievances and report their findings to the individual directly with copies to this Council. These procedures appear to have been followed closely by the county medical societies the past year. During the course of the year, the Council became aware of the activities of the Medical Mediation Committee of the Volusia County Medical Society. It appeared to the Council that this particular Mediation Committee had conducted itself in an exemplary manner in its role of mediating grievances between patients and members of the county medical society. The Council has distributed the activities of the Volusia County Medical Society to other component county medical societies as an example of a highly effective manner of handling grievances.

Regrettably, there have been some instances in which certain county medical societies have not been expedient in reviewing and responding to grievances. These delays are difficult to explain to the party who has filed the grievance and reflect adversely on the county medical society. County medical societies have been encouraged to review their procedures to ensure that grievances are handled as efficiently and expeditiously as possible. The Council, pursuant to the Bylaws of the Florida Medical Association, retains the right to withdraw these grievances from the local society, if they are not acted upon within a reasonable time. An individual may appeal a decision of a local County Medical Society Grievance Committee to the Judicial Council.

In handling grievances, it is important that the county medical society conduct a fair and objective hearing to obtain the facts prior to rendering a decision. Medical societies are urged to review their Constitution and Bylaws to ensure that all procedural safeguards are extended to parties involved in grievances.

Review of County Medical Society Revisions to Charter and Bylaws

During the past year, the Council continued to review and advise county medical societies in respect to bylaw amendments. The Council reviews changes to bylaws to ensure that amendments are not in conflict with the Bylaws of the Florida Medical Association. County medical societies are urged to submit proposed changes in charters and bylaws to the Judicial Council in a timely manner so that they may be reviewed.

During the past year, the House of Delegates adopted a recommendation of the Judicial Council to create the Hernando County Medical Society and will act this May on a proposed recommendation of the Judicial Council to create the Bradford County Medical Society.

Florida Medical Association Policy Statement Re: Advertising (1979)

During the past year, the Council amended the endorsed specialty listing section of the Florida Medical Association Policy Statement on Advertising to include the following new approved listings:

Ear, Nose and Throat (See Otolaryngology — Head and Neck Surgery)
Genetic Medicine
Vascular Surgery
Hand Surgery
Oral and Maxillofacial Surgery

Opinions of the Judicial Council

During the past year, the Council rendered the following opinions:

1. **Opinion 84/1:** It is the opinion of the Judicial Council that the practice of charging home health care service agencies for signing forms covering services to a physician's patient is considered to be an unwarranted and unethical practice not in conformity with the Principles of Medical Ethics of the American Medical Association or the Florida Medical Association and not in the best interest of the patients or the medical profession.
2. **Opinion 84/2:** It is the opinion of the Judicial Council that it does not perceive potential conflict of interest as a result of a group of physicians owning an interest in a clinical laboratory and referring patients to that laboratory, provided the patient is advised of the physicians proprietary interest in the laboratory and thus has the opportunity to choose freely between and among competing laboratories.

Information

The Council, along with the thousands of physicians in the state of Florida who knew of his service to organized medicine, was saddened this past year by the passing of John J. Cheleden, M.D., of Ormond Beach, who died on November 9, 1983. The Judicial Council joins the many friends of Dr. Cheleden in

expressing its admiration for this distinguished and thoughtful servant of organized medicine. It was primarily through Dr. Cheleden's efforts that the Judicial Council gained the degree of credibility it has achieved over the years. Dr. Cheleden completed his term of the Judicial Council in 1977, serving the last six years as its Chairman.

Florida Medical Foundation

The Report of the Florida Medical Foundation, with the exception of those items referred to other Reference Committees, was adopted as amended.

Florida Medical Foundation
Eugene G. Peek Jr., M.D., Chairman

The Florida Medical Foundation plays a major role in Florida medicine through varied activities. The Board of Directors of the Foundation has continued to hold their meetings in conjunction with the meetings of the Florida Medical Association Board of Governors. The major activities of the Foundation are summarized as follows:

1. **Peer Medical Utilization Review (PMUR):** This year saw the reestablishment of the Foundation's Peer Medical Utilization Review Program. This service is currently being provided under contract with: Blue Cross and Blue Shield of Florida, Inc., for Medicare, the Department of Health and Rehabilitative Services for Medicaid, and the Division of Workers' Compensation. Because of rulings by the United States Supreme Court, the Foundation has suspended the health insurance review program previously provided to the major health insurance carriers in Florida.
2. **Committee on Impaired Physicians:** Included in the *Delegates' Handbook* is a report on the activities of the Committee on Impaired Physicians. This Committee continues to provide a tremendous service with outstanding results.
3. **Emergency Medical Services Project:** Included in the *Delegates' Handbook* is a report on the activities of the Committee on Emergency Medical Services. The Committee is currently working with the Department of Health and Rehabilitative Services Emergency Medical Service Office in the development of a five-year plan to implement a statewide system incorporating the recommendations of the FMF Emergency Medical Services Project. Also, the Committee has assisted in finalizing the "Statewide Analysis of Emergency Medical Services and Critical Care" which is currently being provided to interested parties by the Department of Health and Rehabilitative Services.
4. **Medical Student Loans:** The Florida Medical Foundation has made progress in collecting delinquent student loans. Five of the loans under the Florida Medical Foundation Student Loan Program, for which the Foundation serves as the guarantor, were paid off by the recipients, leaving thirty-one loans still on an active basis. In the past four years, several loans have been paid off by the Foundation due to serious delinquencies at the request of the bank which originally made the loans to the students. The total amount of these loans originally was $32,877.32, but with the collection efforts, the total is now $25,304.29. Six of the loans are currently in repayment with monthly payments being made. Four of the loans have been turned over to a collection agency as authorized by the Foundation Board of Directors.
5. **Committee on Continuing Medical Education:** The Committee as an organization accredited by the Accreditation Council for Continuing Medical Education (ACCME) and the Florida Medical Association, continues to make major contributions to continuing medical education in Florida. In 1983, the Committee reviewed and approved 38 applications from specialty groups, hospitals and other CME providers for a total of 516 hours of American Medical Association Category I credit. Additionally, members of the Committee have actively served as members of site survey teams for the accreditation of hospital-based programs of continuing medical education. The activities of the Committee continues to assure physicians of Florida that educational programs offering AMA Category I credit are of the highest quality.
6. **Florida Medical Association Auxiliary:** A very special expression of appreciation goes to the Florida Medical Association Auxiliary which, through its many efforts, has donated in excess of $5,500 to the Foundation in 1983.

Florida Medical Foundation
Committee on Impaired Physicians

The Report of the Florida Medical Foundation Committee on Impaired Physicians was adopted as presented.

Florida Medical Foundation
Committee on Impaired Physicians
Guy T. Selander, M.D., Chairman

Encouraged and assisted by strong support from the FMA Board of Governors, the Committee on Impaired Physicians is completing what by virtually any standard is the most successful and productive year in its four-year history.

The year 1983-84 brought into focus the realization of two important goals long pursued by the Committee, i.e., the employment of a full-time medical director for the program, and coverage of treatment of chemical addiction in the FMA sponsored health insurance plan for members. There were other accomplishments also, such as the birth of the Committee's new quarterly newsletter, the presentation of two additional intervention workshops, and the formation of additional county medical society impaired physicians committees.

By the time this report was prepared, the Committee had met three times since its 1982-83 Annual Report was submitted — at Hollywood on May 6, 1983; at Orlando on September 23, 1983, and at Jacksonville on December 2, 1983. Additional meetings are planned for West Palm Beach on March 3, 1984, and in Jacksonville on March 31, 1984.

The various accomplishments and activities of the Committee since May 1983 are summarized in this report under appropriate headings:

1. **Caseload:** During the period February 1, 1983 to January 31, 1984, 46 professionals, including 36 medical doctors, were seen in the program. There were also eight dentists and two veterinarians. Of the physicians, four were found upon evaluation to have psychiatric problems and were referred outside the program for treatment. Of the remainder, 19 physicians required four months or more of treatment, five for alcoholism and 14 for drug addiction.

   Since the program began in January of 1981, 150 professionals have been seen. The group included 128 M.D.s (52 alcoholism, 71 drug addiction and 5 psychiatric illness). There have also been 12 dentists, 2 osteopaths, 5 pharmacists and 3 veterinarians.

   Thirty-four professionals, including 30 doctors of medicine, have been chemical free for more than two years.

2. **Full-time Medical Director:** Because of an increase in the Committee's budget for CY 1984 which was approved by the Board of Governors, the Committee is in the midst of a search for a full-time medical director for the Impaired Physicians Program. The search has been publicized in advertisements in *The Journal of the American Medical Association* and in *The Journal of the Florida Medical Association, Inc.*, as well as in memoranda to other state medical associations and notices in other FMA publications.

   Applications will be accepted until March 15, 1984, after which the Committee likely will personally interview two or three of the most promising candidates prior to making a recommendation for appointment to the Board of Governors at either its May or June Meeting. It is hoped that the new medical director will be on the job by late summer or early fall, succeeding Dolores A. Morgan, M.D., who has held the post on a part-time and temporary basis for three and a half years.
3. **Insurance Coverage:** Another milestone in the Impaired Physicians Program was passed in 1983 when the Florida Medical Insurance Trust (FMIT) began to provide benefits for impaired physicians when they are treated for alcohol or drug problems. Inpatient hospital charges will be paid at 80% with a $25,000 lifetime maximum. Benefits also are provided for inpatient and outpatient physician charges, and all other services. The coverage was made effective November 1, 1983.
4. **FMF Impaired Physicians Newsletter:** At the suggestion of FMA President J. Lee Dockery, M.D., the Committee has developed the *FMF Impaired Physicians Newsletter*. The *Newsletter* made its first appearance as an insert in the January 1984 issue of *The Journal of the Florida Medical Association, Inc.* It will be published quarterly (in January, April, July and October), and copies will be sent regularly to all state impaired physicians committee chairmen.
5. **Journal Article:** A special article entitled "The FMA-FMF Impaired Physicians Program: The First 25 Months" was published by co-authors Guy T. Selander, M.D., Chairman of the Committee on Impaired Physicians, and Mrs. B. David (Edie) Epstein, FMA Auxiliary Representative on the Committee, in the October 1983 issue of *The Journal of the Florida Medical Association, Inc.*
6. **Intervention Workshops:** Approximately 40 physicians and others attended the Committee's Fourth Workshop on Intervention with Impaired Physicians in Orlando on Saturday and Sunday, September 24-25. The fifth such workshop is planned for Jacksonville on March 31 and April 1. These two-day workshops use lectures, film and role-playing to educate physicians and others concerning chemical dependency among physicians, the substances most commonly abused, the techniques and intervention, relapse and other aspects. AMA Category I Credit and AAFP Prescribed Credit are awarded to physicians attending these sessions.
7. **Section on Chemical Dependency:** As part of its continuing commitment to provide up-to-date scientific information on chemical addiction to the medical profession in Florida, the Committee will sponsor, for the fourth consecutive year, a Section on Chemical Dependency during the 110th Annual Meeting of the Florida Medical Association. The Section will be presented on Thursday afternoon, May 3, from 1:30 p.m. to 4:30 p.m., and all physicians registered for the meeting are cordially invited to attend.
8. **Approved Treatment Facilities** — The Committee has approved four alcohol and drug treatment facilities in Florida to receive patients under the IPP. These are South Miami Hospital, Miami; Palm Beach Institute, West Palm Beach; Lakeland Regional Medical Center, Lakeland; and Horizon Hospital, Clearwater.

   Palm Beach Institute's two-year provisional period of approval expires in May, and the Committee scheduled a site survey preliminary to reapproval for March 3, 1984.

   The Committee has prescribed six basic criteria for institutional participation in the Impaired Physicians Program. An approved facility must:

   a. have been in the business of treating chemical dependency cases for at least four years;
   b. be accredited by the Joint Commission on Accreditation of Hospitals;
   c. have direct medical involvement in the treatment program;
   d. have relationships with Alcoholics Anonymous and Narcotics Anonymous;
   e. have a family-centered care program; and
   f. have an after-care program.

9. **CMS Impaired Physicians Committees:** The Committee continues to promote the formation of impaired physicians committees within each FMA county medical society regardless of size. Despite intense efforts toward this goal over the past year, we still have 18 county medical societies that have no committee apparatus to deal with impairment. The new medical director will be instructed to make a major thrust in this area once he is on the job.
10. **Board of Medical Examiners:** The Board of Medical Examiners Impaired Physicians Advisory Committee continues to follow a path different from that of the FMA-FMF program. Liaison members of that Committee include Guy T. Selander, M.D., Chairman of the FMF Impaired Physicians Committee, and Mrs. B. David (Edie) Epstein, a member of the FMF Committee on Impaired Physicians who represents the FMA Auxiliary on the Board of Medical Examiners Committee.
11. **PADS Project:** Joseph H. Deatsch, M.D., and Guy T. Selander, M.D., both of Jacksonville, represent the FMA on the policy group of the Prescription Abuse Data Synthesis (PADS) project. This group meets regularly in Tallahassee and consists of representatives of the FMA Committees on Impaired Physicians (Dr. Selander) and Substance Abuse (Dr. Deatsch), Florida Pharmacy Association, the Florida Department of Law Enforcement, the Drug Enforcement Administration, the Florida Department of Professional Regulation, the Florida Department of Health and Rehabilitative Services and other groups.

    The project seeks to use existing data and other resources to identify drug diversion among health care providers (physicians, dentists, nurses, pharmacists, etc.). Physicians identified as sources of diversion are further categorized as being:

    a. dishonest or "script" doctors;
    b. disabled or impaired doctors;
    c. duped doctors; or
    d. dated doctors.

    An intervention protocol was developed by the FMA representatives in consultation with the Chairman, FMA Committee on Substance Abuse, and was submitted to the PADS policy group for inclusion in this report.

Florida Physicians' Insurance Reciprocal

The Report of the Florida Physicians' Insurance Reciprocal was adopted as presented.

Florida Physicians' Insurance Reciprocal

W. Harold Parham, D.H.A., President

As the Reciprocal enters its ninth year of providing insurance coverage, the malpractice scene in Florida has continued to worsen as subsequent figures in this report clearly indicate. The numbers and severity of claims has steadily escalated and efforts directed toward risk management seminars, energetic defense of meritorious claims, and attempts at significant legislative relief have not overcome the overwhelming legal and social problems associated with these claims. Increases in premiums have been directly related to the increase in frequency and the severity of claims which is particularly due to the erosion of the tort reforms passed by the Florida Legislature and either disregarded or declared unconstitutional by our Judiciary.

Since the inception of the Florida Medical Association Program (1963), there has been an increase in claims frequency of 550 percent (now approaching one out of three physicians per year — 29.9 per 100 physicians). At year end 1983, the Reciprocal had paid 305 and reserved 88 claims in excess of $100,000 and prior to 1968 there were none. There were no claims exceeding $1,000,000 prior to March 1979; now such awards have become commonplace.

In 1983, the Reciprocal had:

— A premium income of $40,696,374;
— A net underwriting loss of ($12,401,922);
— A net investment income of $4,203,424;
— For a net operating loss for the year of ($8,198,498).

During 1983 the Reciprocal settled 219 cases which for indemnity and expenses exceeded $43,360,000 which was an average cost of settlement of $198,000 each. In 1963 the average cost per claim was $4,138.

Due to the continued escalation of large claims and awards, it has been necessary for the Reciprocal to call upon each Board Member to make an even larger contribution of their time and expertise.

During the year, your Chairman was requested by the Board to accept the additional responsibility of Medical Director and devote considerably more of his time and talents specifically to concentrate upon large claims.

Mr. John Thrasher was transferred from an executive position with PIMCO and appointed Deputy Attorney-in-Fact, Vice President and Legal Counsel to provide backup and continuity for the Attorney-in-Fact/President and to assist the Chairman with the defense of large claims.

The Reciprocal's insureds have decreased from a high of over 6,800 physicians to approximately 4,396 in the last 25 months (January 1, 1982 through January 1984). Many have obtained their coverage with the St. Paul which reentered the Florida market after taking a walk in the early 70's when the crisis began, and with other companies left Florida physicians with no availability of insurance.

The Reciprocal has attempted to be innovative in meeting the needs of the physicians it insures and has adopted:

— Quarterly payment of premiums;
— An eight classification rating system;
— Reduced the coverage available through the Reciprocal from $6.5 million to $1.5 million due to the tremendous exposure with the excess coverage and the tendency of claims to increase to the maximum amount of coverage;
— Removal of the "claims-free" provision for free tail coverage for death and disability and normal retirement (the probability of one out of three physicians being sued sometime during their lifetime made the claims-free restriction impractical).

The Florida Senate, last year, adopted a legislative package which would have had a direct effect on decreasing the rate of increase for professional liability insurance; however, the Speaker of the House (a plaintiff's attorney) would never let it come to the House floor for a vote when our review indicated adequate support for it to pass.

The FMA will continue its attempts in the Florida Legislature, but even more importantly, the FMA House of Delegates has approved a program of tort reforms through a constitutional amendment initiative. With the proper support from physicians and all others concerned with the escalating cost and abuse in our tort system, it will be adopted and have a dramatic effect upon the future of professional liability in Florida; they are:

1. Summary Judgments;
2. Limitations of $100,000 for Non-economic Damages;
3. Elimination of Joint and Several Liability.

When constitutional reforms are adopted in November, it will not immediately solve the problem because of the many suits currently in the system. With Florida's 2-2 and 4 year statute of limitation, it will be some time before there will be a reduction in the escalating cost of professional liability insurance. In all probability, based upon our past trends, premiums will still increase during this period of time.

The Reciprocal remains committed to a policy of fiscal and actuarial soundness. Because of this, the Reciprocal enjoys continuous and uninterrupted support of many of the major reinsurance markets primarily in London, including Lloyd's of London. These are the bedrock supports that will enable your Reciprocal to continue to provide responsible protection to the participating insureds in this program.

The Reciprocal has as an aggressive investment policy as possible, but the rapid decline in the money market funds and the ups and downs of the bond market made it a very difficult year.

Your Reciprocal has made some limited investments in limited partnerships which have proven to be most rewarding.

A quote from our Annual Report for 1982 is just as appropriate today as when it was written.

> "No individual with reason and logic may refute the fact that we are faced with a severe malpractice crisis, not from the standpoint of availability, but from the spiraling uncontrolled cost and excessive amount of monies being paid for liability in this state when in many instances there is no negligence on the part of the physician, and awards are being made for death and disability, pain and suffering, etc., and no one has paid a premium to cover these costs."

When the members of the Florida Medical Association felt the crushing blow from all major insurance companies leaving the state of Florida, and the FMA group program with the Argonaut Insurance Company being challenged in the federal courts in the spring of 1975, it was quite obvious that the availability of professional liability insurance would be non-existent by the end of 1975.

The leadership of the FMA recommended and the Board of Governors and the House of Delegates directed that an insurance mechanism be established, free standing, in the private sector. This resulted in the establishment of the FMA-PLI Trust in 1975. It commenced writing professional liability indemnification on December 1, 1975, and was replaced by the Florida Physicians' Insurance Reciprocal on December 31, 1976, due to the undesirability of the Trust's assessability feature.

PIMCO (Professional Insurance Management Company), established by the FMA, was the successor of Harlan-Med, Inc., (an insurance company partially owned by the FMA) to serve as a

general insurance agency to administer the FMA-sponsored programs and to serve as the management company for the Trust and the Reciprocal. James W. Walker, M.D., continues to serve ably as its President and Chief Executive Officer supported by an experienced staff, and advised by an outstanding Board of Directors.

The reinsurance brokers for the Reciprocal are: The Wetzel Company, Inc., Austin, Texas; Caribe-Re, Ltd., (jointly owned by the Wetzel Company and the Reciprocal); and the Robert Fleming Insurance Brokers, Ltd., London.

The firm of Tillinghast and Warren, a national actuarial group who provides service for many physician-owned companies in America, serves as consulting actuaries for the Reciprocal.

The Certificd Public Accountants for the Reciprocal are Harbeson, Beckerleg, and Fletcher, in Jacksonville, Florida.

Barnett Banks Trust Company, N.A., serves as custodian for investments owned by the Reciprocal and the Reinsurers (Lloyd's) Trust Accounts.

Professional Capital Management Company (who serves as investment advisors for a number of insurance companies) serves as Investment Manager and Ehlers and Company serves as investment advisor for the Reciprocal.

The Reciprocal offers a basic policy of $500,000 with multiples for excess coverage up to $1,500,000. There is no aggregate; it is modified claims-made, with a provision for death, disability and normal retirement.

The Reciprocal offers first and second year physicians a premium that is highly competitive and should be equivalent and comparable to similar coverage offered by any other carrier in Florida. To accommodate the individual physicians or physicians in groups desiring deductibles, the Reciprocal provides policies with deductibles in the amount of $25,000-$50,000-$75,000-$100,000 with the appropriate reduction in premiums up to 42 percent to accommodate the lesser liability by the company.

The Reciprocal's expense ratio is one of the lowest in the nation. You will note from the Financial Report that the corporate expenses of the Attorney-in-Fact/President (including Actuaries, CPA's, State Guaranty Fund, etc.) plus the management fees paid to PIMCO (for underwriting, claims, risk management, etc.) approximates 7 percent of premium income.



Newly elected President-Elect Luis M. Perez, M.D., of Sanford, addresses the House of Delegates.

SUMMARY OF FINANCIAL REPORT
FOR YEAR ENDING DECEMBER 31, 1983

Total Premium for Insurance Coverage		$40,696,374
Less: Reinsurance paid for coverage in excess of $250,000 retention		(22,875,241)
Earned premium for death, disability and normal retirement		739,075
Net Premiums Earned		18,560,208
Losses: (Incurred Losses)	(21,699,590)	
(Loss Expense)	(6,255,779)	(27,955,369)
Corporate Expenses — Attorney-in-Fact	(604,095)	
Taxes, Licenses and Fees	(52,666)	(656,761)
Management Fees Paid — PIMCO		(2,350,000)
Net Underwriting (Loss)		(12,401,922)
Net Investment Income Earned	4,749,925	
Net Realized Capital (Loss)	(546,501)	
Net Investment Gain		4,203,424
Surplus Relief (Sale of Reserve for Losses)		10,630,000
Federal Income Tax		— 0 —
Net Income (Loss)		2,431,502
Capital & Surplus Account		
Surplus 12/31/82		7,574,847
Surplus Relief	10,630,000	
Operating (Loss)	(8,198,498)	
Net Income		2,431,502
Subscribers Deposits		2,833,265
Net Unrealized Capital Gain		1,041,741
Statutory Adjustment		68,682
Surplus 12/31/83		13,950,037
Premium to Surplus Ratio		1.28:1

Florida Medical Political Action Committee (FLAMPAC)

The report of the Florida Medical Political Action Committee (FLAMPAC) was adopted as presented.

Florida Medical Political Action Committee (FLAMPAC)

Robert E. Windom, M.D., President

Membership

The year 1983 was an extremely successful one for FLAMPAC membership recruitment. The year-end total of 6,185 was in excess of membership for any previous year in FLAMPAC's history. FLAMPAC was notified by the American Medical Political Action Committee that it would receive three national awards for its 1983 membership recruitment activities. These were:

First Place: Members to Potential
First Place: Largest Increase Over Prior Year
Third Place: Total Contributions

1984 membership solicitations emphasized sustaining membership for all physicians and their spouses recruited. While complete membership totals are not in yet, early receipts indicate that approximately 75 percent of those persons joining FLAMPAC in 1984 are joining at the sustaining membership level. This will provide an extremely solid financial base for FLAMPAC to participate in for the 1984 elections.

FLAMPAC Board Reorganization

The FLAMPAC Bylaws were amended to provide for an expanded Board of Directors. The primary objective of the reorganization was to provide for in-depth communication with local areas, particularly with regard to candidate evaluation and selection. Three primary operating committees have been appointed. The committees and their chairmen and vice chairmen are as follows:

Membership:	Dick L. Van Eldik, M.D., Chairman Mrs. Thomas M. Caswall, Vice Chairman
Political Education:	Warren Lindau, M.D., Chairman Thomas M. Caswall, M.D., Vice Chairman
Candidate Evaluation:	James G. White, M.D., Chairman Mrs. B. David Epstein, Vice Chairman

FLAMPAC Officers

The Board elected the following four persons as officers for FLAMPAC during 1984:

Robert E. Windom, M.D., President
James G. White, M.D., Vice President
Carlos G. Llanes, M.D., Secretary
Louis C. Murray, M.D., Treasurer
Donald C. Jones, Assistant Treasurer

Florida Physicians Association

The Report of the Florida Physicians Association was adopted as presented.

Florida Physicians Association

David T. Overbey, M.D., President

The Florida Physicians Association is a non-profit corporation founded in December 1972 to protect the private practice of medicine by becoming involved in activities that the Florida Medical Association cannot enter into because of Charter restrictions and legal ramifications.

As of February 29, 1984, the Florida Physicians Association has 4,970 members and is expected to grow even larger by the Annual Meeting.

The Board of the Florida Physicians Association approved the allocation of $25,446.08 to assist eleven county medical societies with the cost of newspaper ads regarding the 1983 professional liability effort. It is anticipated that similar requests will be considered by the Board once the 1984 professional liability program starts to be implemented.

Also, the Board of the Florida Physicians Association anticipates that they may be called upon to provide assistance to county medical societies as they develop programs to counter the rapid growth of HMOs, PPOs and other prepaid health delivery efforts.

RESOLUTION 84-1
Comprehensive Professional Liability Insurance Coverage

Bay County Medical Society

The motion of the Reference Committee that Resolution 84-1 be referred to the Board of Governors carried.

RESOLUTION 84-1
Comprehensive Professional Liability Insurance Coverage
(Not adopted — Referred to Board of Governors)

Whereas, There is a need to provide an alternative policy to those physicians who have had to "go bare" because of the high cost of traditional malpractice policies; and

Whereas, To also provide for defense against punitive claims (not now covered by our current malpractice policy); and

Whereas, such a policy would indicate to the plaintiff and plaintiff's attorney that the defense has the financial capability to continue the legal proceedings through the entire appeal process, yet without any award money in this policy; and

Whereas, The Association and its insurance reciprocal should consider providing this type of policy as a basic policy for all its members and create a separate or "modular" policy for those members who wish to purchase protection against unfavorable settlements/awards, malpractice and/or punitive; therefore be it

RESOLVED, That PIMCO, (the Florida Physicians' Insurance Reciprocal) be requested to make available an insurance policy covering the entire defense costs to their absolute legal termination of any medical malpractice action(s) and/or punitive action(s) brought against the insured, without sharing the responsibility for the ultimate settlement in the case.

RESOLUTION 84-5
Verification of Listings in Commercial Directories
Dade County Medical Association

A motion from the floor was carried to amend the "Resolved" portion of the Resolution to read as follows:

"RESOLVED, That the FMA be requested to encourage the publishers of all commercial directories, such as the Yellow Pages, to verify the names of physicians with the State Board of Medical Examiners before permitting the listing of a physician in any such directory in the state of Florida."

Resolution 84-5 was adopted as amended.

RESOLUTION 84-5
Verification of Listings in Commercial Directories

RESOLVED, That the FMA be requested to encourage the publishers of all commercial directories, such as the Yellow Pages, to verify the names of physicians with the State Board of Medical Examiners before permitting the listing of a physician in any such directory in the state of Florida.

RESOLUTION 84-6
Voluntary Fee Freeze
Dade County Medical Association

Upon recommendation of the Reference Committee, Resolution 84-6 was not adopted and received as information only since the intent of Resolution 84-6 was also contained in Report C of the Board of Governors previously considered.

RESOLUTION 84-7
FMA/CMS Communications Through MINET
Broward County Medical Association

Since no sponsor appeared before the Reference Committee to support Resolution 84-7, it was not considered.

RESOLUTION 84-8
Meetings of the FMA Board of Governors
Broward County Medical Association

Resolution 84-8 was not adopted.

RESOLUTION 84-10
Doctor/Patient Relationships
Broward County Medical Association

Since no sponsor appeared before the Reference Committee to support Resolution 84-10, it was not considered.

The Chairman expressed his thanks to each member and alternate member of the Reference Committee: Wilbert L. Dawkins, M.D.; Robert E. McCammon, M.D.; A. Frederick Schild, M.D.; Douglas R. Murphy, M.D.; and Richard J. Bagby, M.D., (Alternate) for their diligent attention to the business of the House of Delegates. Special thanks were conveyed to the Committee's AMA Delegate Advisors, T. Byron Thames, M.D. and Vernon B. Astler, M.D. The Committee also expressed its appreciation to W. Harold Parham, D.H.A., Executive Vice President; Mr. Donald C. Jones, Executive Director; Ms. Kriss Hanley, Recorder; and FMA staff members for their support of the Committee and to the many members of the Association who attended the meetings of Reference Committee III and presented testimony.

The motion that the Report of Reference Committee No. III be adopted as amended carried.



New President-Elect Luis M. Perez, M.D. gives an appreciative hug to his wife Maria P. Perez, M.D.

The Speaker called Dr. J. Lee Dockery to come to the podium to present the Certificate of Merit and Certificate of Appreciation as commendations for exceptional and outstanding service to the Association, to the medical profession, and to the public in accordance with the Principles of Medical Ethics. This year's recipient of the Certificate of Merit, Dr. Edward R. Annis of Miami, was escorted to the podium by Dr. Daniel L. Seckinger and Dr. Charles A. Dunn to receive his award.



Former AMA President Edward R. Annis, M.D. of Miami (left) accepts the Florida Medical Association Certificate of Merit from President J. Lee Dockery, M.D.

CERTIFICATE OF MERIT

Edward R. Annis, M.D.

Whereas, Edward R. Annis, M.D., of Miami, Florida, has rendered exceptional service to the Florida Medical Association, to organized medicine and to the public; and

Whereas, This dedicated physician was born in Detroit, Michigan, on March 27, 1913, attended the University of Detroit and was graduated with a Doctor of Medicine degree from the Marquette University School of Medicine; and

Whereas, This eminent gentleman served his patients with devotion as a surgeon for many years and has continued to serve the medical profession and the public as a spokesperson, consultant and lecturer; and

Whereas, Dr. Annis has spent his entire career in efforts to improve the quality and value of health care and in speaking out on behalf of organized medicine on such topics as preventive medicine, health care legislation and health care costs; and

Whereas, This distinguished individual is a dedicated participant in civic affairs having served as a member of the Senior Citizens Division of the Welfare Planning Council in Miami, on various health care related committees by appointment of Governor of the State of Florida and as a Director of the United States Chamber of Commerce for six years and as National Director of the United States Jaycees for two years; and

Whereas, This eminent physician was the President of the American Medical Association, of the World Medical Association and of the United States Section of the International College of Surgeons; and

Whereas, Dr. Annis was seen and heard by a television audience of millions of people as he spoke out on behalf of organized medicine against President Kennedy's demand for socialized medical care from a dark and deserted Madison Square Garden in 1962; and

Whereas, This able individual continues to serve his profession as the Chairman of the Florida Medical Association Speakers Bureau and as a consultant to many medical organizations; and

Whereas, Dr. Annis has given freely of his time and talents to the medical community and to the people of the state of Florida and the world, therefore be it

RESOLVED, That a Certificate of Merit be presented to Edward R. Annis, M.D., as a token of the warm regard and respect that the officers, members and executive staff of the Florida Medical Association hold for the many years of outstanding service rendered by this fine gentleman.

Dr. Annis expressed his appreciation to the Association for bestowing him with this award.

Dr. Dockery then announced the recipient of the Certificate of Appreciation, Dr. Louis C. Murray of Orlando, and asked that he be escorted to the podium by Dr. Wallace M. Philips Jr. and Dr. James F. Richards Jr. to receive his award.

CERTIFICATE OF APPRECIATION

Louis C. Murray, M.D.

Whereas, Louis C. Murray, M.D., of Orlando, Florida, has tirelessly and ably served the medical profession and the citizens of Florida for more than 30 years; and

Whereas, Dr. Murray was born in New York, New York, on August 12, 1924, attended Villanova University, the University of Florida and Tulane University and received his medical degree from Hahnemann Medical College in 1953; and

Whereas, This honorable individual served in the United States Army, Pacific Theatre, from 1942 until 1946; and



FMA Council on Legislation Chairman Louis C. Murray, M.D. of Orlando (left) accepts the FMA Certificate of Appreciation from President J. Lee Dockery, M.D.

Whereas, This dedicated family physician completed an internship at Orange Memorial Hospital in Orlando and then entered the private practice of Family Medicine in that city and is still engaged in that practice; and

Whereas, Dr. Murray was President of the Florida Medical Association in 1977-78; and

Whereas, This able physician has served both the Florida Medical Association and the American Medical Association on various committees since 1954; and

Whereas, This capable leader has held numerous positions while a member of the Florida Medical Association and was a member of the original Committee of 17 to Blue Shield of Florida; and

Whereas, This fine physician is currently Chairman of the FMA Council on Legislation, a position he has served with diligence since 1980; and

Whereas, Dr. Murray has been a member of the Orange County Medical Society since 1954 and was its President in 1968; and

Whereas, He has been a member of the American Medical Association House of Delegates since 1980; and

Whereas, Dr. Murray is a Diplomate of the American Academy of Family Physicians and is a Past President of the Florida Academy of Family Physicians; and

Whereas, This respected physician was a member of the Board of Regents, State University System of Florida, from 1965-1972 and served as its Vice Chairman for three years and as Chairman of its Curriculum Committee for four years; and

Whereas, He has served as Chairman of the Medical Advisory Committee of the University of Florida College of Medicine; and

Whereas, He served the University of Central Florida as a member of the President's Advisory Committee, as a Clinical Professor of the Allied Health Sciences, and as Chairman of the Advisory Committee of the College of Health; and

Whereas, This community leader has received a Distinguished Alumni Award from the University of Florida, a Recognition Award of Dedication and Devotion to Education from the University of Central Florida, with the University Foundation and Orlando Area Chamber of Commerce, and an Elks Tangerine Bowl Committee Outstanding Service Award; and

Whereas, Dr. Murray has been active in the Orlando Chapter of the American Cancer Society, Magnolia Towers Retirement Center Board of Directors, and the Greater Orlando Area Chamber of Commerce; and

Whereas, Dr. Murray has continually given of his time and talents for the enhancement of quality health care for all citizens; therefore be it

RESOLVED, That a Certificate of Appreciation be presented by the Florida Medical Association to Louis C. Murray, M.D., as a token of the warm appreciation that the officers, members and executive staff of the Association hold for this fine gentleman and his exemplary record of service to mankind and to his profession.

Dr. Murray expressed his sincere appreciation for having received this award and also reaffirmed his continued loyalty and dedication to the Association.

New Charter

Bradford County Medical Society

Dr. Dockery then advised the members of the House that in keeping with involvement in organized medicine, the Association has been able to charter a new county medical society, the Bradford County Medical Society. In the absence of Dr. Pete G. Felos, Vice President of the Bradford County Medical Society, Dr. Dockery asked Dr. Charles P. Gibbs, President of the Alachua County Medical Society, to accept the charter on behalf of the Bradford County Medical Society.



Reference Committee III examines all business related to Finance and Administration. Paul A. Flaten, M.D, of Ft. Lauderdale, addresses the House of Delegates.

Report of Reference Committee No. IV Legislation and Miscellaneous

Dr. Perry called the Chairman and members of Reference Committee No. IV, Legislation and Miscellaneous, to present their report.

Dr. Fred S. Carter, Chairman, and his Committee came forward to present the report of Reference Committee No. IV, Legislation and Miscellaneous.

The Committee expressed its desire to publicly commend Dr. Louis C. Murray for his outstanding work in his role as Chairman of the Council on Legislation. The Committee further recognized and commended FMA staff members, Mr. Donald S. Fraser Jr., Deputy Executive Director; Mr. George S. Palmer Jr., Assistant Director, Legislative Affairs; Mr. Jim McCloy, Assistant Director, Legislative Affairs; Mrs. Nancy Moreau, Legislative Analyst; and all other FMA staff members who worked on the FMA's legislative program for their outstanding service. The Committee also recognized the contributions of all members of the Florida Medical Association who participated in FMA legislative activities during the past year.

Report D of the Board of Governors

The Reference Committee heard discussion during the consideration of Report D of the Board of Governors concerning the fact that important rules and regulations regarding the practice of medicine are being promulgated without a hearing having been requested or held. This activity, in the opinion of the Committee, leads to the adoption of rules and regulations that may adversely affect the practice of medicine, and as a result the Committee presented an Addendum to Report D.

A motion carried from the floor to amend the Addendum to Report D by adding the following sentence: "That the FMA participate in a program of legislative reform in this most important area of the promulgation of rules."

The motion of the Reference Committee that Report D of the Board of Governors be adopted, together with the Addendum as amended, carried.

Report D of the Board of Governors

J. Lee Dockery, M.D., Chairman

Board Actions of Major Importance

FLAMPAC

Membership: The Board expressed commendations to FLAMPAC for another record year of membership during 1983. The Board reaffirmed the critical need for physicians and their spouses to continue to increase active participation in FLAMPAC and the political process.

Board Composition: The Board approved a modification to the FLAMPAC Bylaws to allow for an expansion of the Board of Directors to 34 members, the majority of which shall be physician members of the FMA.

Local Support Committees: The Board approved an amendment to the FLAMPAC Bylaws for selection of members and Chairmen of local FLAMPAC Support Committees to provide:

> "That members of the local FLAMPAC Support Committee shall be chosen by local FLAMPAC members. The number of physicians and spouses serving on the Committee shall be determined by the local FLAMPAC Support Committee. The Chairman of the local FLAMPAC Support Committee shall be nominated by the county medical society president and approved by the FLAMPAC Board of Directors; and shall serve for a period of one year."

A comprehensive report on the activities of FLAMPAC during the 1983-84 Association year is included in the *Delegates' Handbook*.

FMA Councils and Committees

COUNCIL ON LEGISLATION

1983 Legislative Session: The Board received an extensive report on the actions taken on major health issues by the 1983 Legislature. It was noted that the 1983 Session present the most significant challenge that medicine has faced in many years, both from the number of anti-medicine issues as well as the imposing task of seeking major tort reform legislation. A complete report on health issues acted on by the Legislature is summarized in the Annual Report of the Council on Legislation included in the *Delegates' Handbook*.

The Board directed that an in-depth review be conducted of the Association's future legislative posture on key issues affecting health care.

Professional Liability: (Also see Report C of the Board of Governors included in the *Delegates' Handbook).*



Reference Committee IV (Legislation and Miscellaneous) was chaired by Fred S. Carter, M.D., Jensen Beach. Left to right: Richard H. Ciordia, M.D., Alternate, Pensacola; Ernest G. Sayfie, M.D., Hollywood; Ms. Julie Woodman, Recorder; Dr. Carter; Jesse Q. Sewell III, M.D., Marathon; Virgil A. Ponzoli Jr., M.D., Naples; and John H. Parker Jr., M.D.

The Board expressed great disappointment that the leadership of the House of Representatives did not act to allow the full House an opportunity to vote on the professional liability issue prior to the adjournment of the Regular Session of the Legislature. The Board expressed appreciation to the Florida Senate for its decisive and positive actions taken toward resolving the professional liability crisis in Florida by overwhelmingly approving much needed reform in Florida's tort system.

The Board of Governors determined that resolution of the professional liability crisis in Florida on a long-term basis would remain the Association's top priority.

The Board expressed its sincere appreciation to Senator George Kirkpatrick, who served as the primary sponsor for the FMA's tort reform package in the Senate, and commended FMA's Committee on Professional Liability Chairman, Dr. T. Byron Thames and FMA's Immediate Past President, Dr. Robert E. Windom for their exemplary efforts during the past year in working to resolve this serious problem. The Board also commended the many physicians and their spouses, FMA staff and FMA legislative consultants for their outstanding efforts on this issue.

1984 Legislative Session: The Board of Governors and the FMA House of Delegates at its special Called Meeting on January 28, 1984, reaffirmed professional liability as a major legislative priority. Bills have been introduced in the House and Senate for consideration by the 1984 Legislature which embody the same proposals as those approved by the House of Delegates for the constitutional initiative campaign including:

- Summary judgments;
- Limitations on noneconomic damages;
- Elimination of joint and several liability.

The following is a summary of the FMA legislative priorities for the 1984 Session. Additional information on legislative issues affecting medicine will be reported to the House in a supplemental report from the Council on Legislation which will be distributed to delegates at the Annual Meeting.

Support for Legislation:

Positive Legislative Initiatives: The Board approved FMA seeking legislative support for the following programs as important components in an overall effort to improve the health of Florida citizens:

- Hazardous waste monitoring;
- Increasing the drinking age to 21;
- Increased support for medical services for indigent patients.

Constitutional Initiative for Drinking Age: The Board approved the appointment of an FMA representative to the Board of Directors of the organization seeking a constitutional amendment to raise the drinking age in Florida to age 21.

Foreign Medical Graduates: The Board approved the concept of the need for improved quality control over licensure of foreign medical graduates and their ability to stand for licensure examination in Florida; and further, that the proposal by the Florida State Board of Medical Examiners for inspection of foreign medical schools be referred to the FMA Committee on Medical Education for evaluation and recommendation.

Newborn Care: Expanding coverage for newborn children in health insurance policies to include the newborn child of a family member of the insured or subscriber (HB 260).

State Board of Medical Examiners: Removes the prohibition against individuals affiliated with a medical school from serving on the State Board of Medical Examiners.

Osteopathy: Authorizes the licensure of osteopathic physicians by the Florida Board of Osteopathic Medical Examiners.

Opposition to:

- Legislation authorizing use of drugs for treatment of disease by optometrists;
- Creating a new classification of pharmacist known as "Pharmacist Health-Care Consultant" as proposed in Senate Bill 45 and House Bill 104;
- Nurse anesthetist hospital staff privileges;
- Removal of the exemption for records and proceedings of medical staff committees from the Open Records Law;
- Continuation of Chapter 467, F.S., relative to the licensure of lay midwives;
- Legislation requiring hospitals to allow chiropractors access to outpatient diagnostic facilities;
- Legislation permitting hospitals and ambulatory surgical centers to maintain and update records on elective surgery;
- Legislation removing the exemption from the Open Records Law of complaints against regulated professionals, regardless of whether or not probable cause is found;

- Legislation creating a licensure statute for respiratory therapists;
- Proposed changes in the current radiologic technologist law that would increase the educational requirements and make the examination standards more stringent for physician office personnel;
- Legislation mandating state regulation of hospital rates or budgets;
- Legislation mandating the summary of treatment alternatives for breast cancer (HB 279/SB 157);
- Legislation requiring that all health insurers provide a "finder's fee" to individuals who discover an overage in their health insurance policies (HB 179);
- Requiring the directed donation of blood by a donor to a patient who is a relative (HB 241);
- Reducing the amount of time a medical faculty certificate, in lieu of a Florida license to practice medicine, is in effect.

Corneal Transplants: The Board expressed support for the Florida Society of Ophthalmology in opposing an effort to require written authorization from the next of kin of a decedent in corneal transplant cases.

Quintas: The Board authorized the FMA to continue to monitor the problems relating to "quintas" in South Florida and their apparent failure to meet standards required of prepaid health plans by Florida law; and that the FMA suggest that resolution of this issue is more properly one of enforcement of current law and regulation rather than legislative initiative; and further, that the FMA offer its assistance to the State Insurance Commissioner and the Department of Health and Rehabilitative Services as may be helpful in developing an appropriate resolution.

American Association of Retired Persons: The Board encouraged all FMA members who are eligible, to join the American Association of Retired Persons (AARP).

Health Care for the Indigent: The Board requested that the Council on Medical Economics develop specific recommendations for the development of a total health care system for indigent patients and submit its recommendations to the Board of Governors at its next meeting.

Workers' Compensation Law: The Board requested the Governor to veto HB 1277, Workers' Compensation, passed by the 1983 Legislature.

Optometrists Drug Bill: The Board requested the Governor to veto the Optometric Drug Bill (SB 168) passed by the 1983 Legislature.

Addendum to Report D of the Board of Governors

"That the FMA Board of Governors establish a post legislative review committee to work in conjunction with the staff of the FMA Tallahassee Office and the FMA legal counsel to monitor and review the development and proposed adoption of federal and Florida administrative rules and regulations that may be of importance or interest to the practice of medicine generally or to the Florida Medical Association. The review procedure should be such as to allow for a timely request for a formal hearing when a proposed rule would substantially affect the practice of medicine, and further that the FMA participate in a program of legislative reform in this most important area of the promulgation of rules."

Council on Legislation

The motion of the Reference Committee carried to editorially correct the Report of the Council on Legislation by inserting in the section beneath the subheading, Committee on National Legislation, fourth paragraph, the word "which" between the words "Medicare" and "go" so as to read: "Opposition to changes in the reimbursement mechanism to physicians in Medicare which go beyond a short term freeze on physician fees increases or mandate acceptance of assignment as full payment for services."

The motion of the Reference Committee carried that the Report of the Council on Legislation be adopted as editorially amended.

Council on Legislation

Louis G. Murray, M.D., Chairman

Most of the work of the Council on Legislation is accomplished through activities of its two committees: the Committee on State Legislation and the Committee on National Legislation. The report of your Council is submitted as individual reports of the two major committees.

Committee on National Legislation

This Committee consists of the key contact physicians for each member of the Florida delegation of the U.S. Senate and the U.S. House of Representatives. Members of this Committee have kept in close touch with their assigned senators and congressmen on the national legislative matters of interest to the FMA and American Medical Association.

The Association has maintained active liaison with members of the Florida Congressional Delegation on key legislative issues. Numerous conferences in Washington between FMA staff, key contact physicians and selected congressmen were necessary in order to carry out the FMA and AMA policies on these issues. In addition to these individual visits, a comprehensive program of visitations was conducted by FMA key contact physicians and officers with the two U.S. Senators and House members who served on committees with jurisdiction over key health issues. This continuing personal liaison resulted in excellent cooperation from Florida's delegation.

The issues that necessitated major action by the FMA and contact physicians were:

— Support for efforts to phase out federal funding for HSAs.
— Support for legislation to prohibit the FTC from using its authority to preempt state laws relative to professional licensure or tasks professionals may perform.
— Support for efforts to repeal the current federal legislation on HSAs and health planning.
— Opposition to proposals that mandate physician acceptance of Medicare assignment.
— Opposition to federal legislation and regulations that provide different systems for reimbursement of specialties that are primarily hospital-based as compared to non-hospital practice sites.
— Opposition to legislation concerning governmental intervention in the care and treatment of newborns with life-threatening congenital impairments.

The Ninety-Eighth Congress, 2nd Session, promises to be increasingly active in federal health legislation. Among the key issues that will be considered that are of particular interest to the FMA are:

— Monitoring of federal proposals on "competition" such as the Kennedy-Gephardt bill and taking appropriate action in coordination with the AMA to defeat portions of these that would increase government regulation of the delivery of medical care.
— Continue efforts to seek legislation to limit the jurisdiction of the Federal Trade Commission over the learned professions and their state and national organizations.
— Opposition to the expansion of the use of prospective payment and DRG systems to specifically include physicians.
— Opposition to changes in the reimbursement mechanism to physicians in Medicare which go beyond a short term freeze on physicians fee increases or mandate acceptance of assignment as full payment for services.
— Support efforts to repeal the Health Planning and HSA Law.
— Oppose efforts to impose further regulations on the practices of physicians in the hospital setting.
— Oppose legislation concerning governmental intervention in the care and treatment of newborns with life-threatening congenital impairments.
— Oppose efforts making distinctions between physicians accepting 100 percent Medicare assignments and those accepting assignments on a claim-by-claim basis, including the publication of lists with respect to the former.
— Oppose legislative and regulatory efforts to entrust PRO review responsibilities to intermediaries with no physician board representation.
— Oppose efforts to reduce reimbursement for clinical laboratory services to unreasonably low levels.
— Oppose efforts to enact national organ transplant legislation which gives the HHS Secretary authority to designate where and by when certain procedures can be performed.
— Monitor efforts to modify malpractice laws at the federal legislative level.

This will require the Association to continue to maintain close liaison with Florida's Congressional Delegation and with the AMA Washington Office.

Committee on State Legislation

The Committee on State Legislation has had another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized specialty groups. Eight formal meetings of the Committee have been held, along with informal conferences among Committee members as items of an urgent nature arose.

Consistent with the policies developed by the FMA House of Delegates, the Committee has worked closely with the Board of Governors in developing our legislative program for the 1984 Session of the Florida Legislature.

The following items summarize the Committee's activities:

1. The legislative program is continuing to function under the supervision of Donald S. Fraser Jr., Deputy Executive Director, Legislation and Public Affairs. He has been materially assisted by Mrs. Nancy Moreau, Legislative Analyst, George S. Palmer Jr., Assistant Director of Legislative Affairs, and Jim McCloy, Assistant Director of Legislative Affairs. Particularly helpful to the legislative activity has been the FMA Branch Offices. These have greatly increased the Association's ability to maintain liaison with county medical societies, contact physicians and members of the Legislature.
2. The Capitol Dispensary. The Committee placed major emphasis on working with the Capitol Dispensary which has proven to be most important in meeting the needs of legislators and their staffs. Mrs. Linda Bass, R.N., head of the clinic, has continued to provide excellent assistance to the FMA in coordinating the activities of the Dispensary for the Doctor of the Day program.
3. The Committee on State Legislation is continuing to emphasize the need to develop a good key contact physician program in each county medical society in the state. In addition, priority attention has been directed toward increasing the role of the Auxiliary in the Association's efforts.
4. Publications. A *Legislative Bulletin* was published every week during the legislative session and periodically between sessions. *The Bulletin* is designed to give up-to-date information to members of the FMA who are involved in legislative activities. A listing of all bills monitored by the Capital Office is sent on a regular basis to county medical society executives and legislative chairmen. In addition, summaries and copies of key legislative proposals are distributed. Legislative manuals have been published and distributed to key physicians and Auxiliary leaders, and each key contact physician has been given a specially designed notebook for either state or national legislation.
5. 1983 Legislative Accomplishments. During the 1983 Legislative Session, there were more than 300 legislative proposals that required action by the State Legislation Committee or the Capital Office staff. Matters of major interest to the Florida Medical Association were:

Issues Opposed by the Florida Medical Association Which Were Defeated in the 1983 Legislative Session:

— Authorization for establishment of Exclusive Provider Organizations (EPOs) in Florida.
— Authorization for pharmacist "health care consultants" to prescribe directly to patients without physician examinations and diagnosis (HB 666).
— Mandated access to hospital outpatient diagnostic facilities by chiropractors (HB 430/SB 332).
— Mandatory hospital staff privileges for chiropractors (HB 951/SB 591).
— Authorization for chiropractors to inject food and food substances (HB 271).
— Mandatory hospital staff privileges for nurse anesthetists (HB 499/SB 516).
— Authority for the Hospital Cost Containment Board to approve hospital budgets and rates before they can go into effect (HB 880/SB 988).
— Elimination of physician office exemption from the Clinical Laboratory Act and a requirement for direct billing for laboratory services (HB 1295).
— Establishment of "peer review committees" operating under the Department of Professional Regulation that would review and handle complaints about physicians' fees (HB 1324/SB 1146).
— Prohibition against anesthesiologists billing full professional fee for services unless they were physically present throughout the procedure (SB 855).
— Expansion of the definition of physical therapy and elimination of the physician prescription requirement (HB 879/SB 1049).
— Prohibition against physicians accepting assignment unless they are within the 80 percentile of physician charges (HB 881).
— A proposal for hospital staff members to pay $500 user fee, plus 2 percent of total patient billings annually to the hospital in return for use of hospital facilities (PCB 9).

Major Health Issues Opposed by the Association That Passed the 1983 Legislative Session:

- Authorization for optometrists to use and prescribe drugs for both diagnostic and therapeutic purposes (SB 168). This bill was subsequently vetoed by the Governor.
- Authorization for the Hospital Cost Containment Board to gather physician charge data from hospitals (HB 1161).
- Mandatory insurance coverage for lay midwives and nurse midwives (SB 1065).
- Rewrite of major provisions in the Workers' Compensation Law (HB 1277):
  - Establishment of a statewide medical fee schedule with prohibition against regional differentials. Among the criteria to be considered in establishment of the statewide fee schedule are the following:

    "In establishing the maximum reimbursement schedule, the panel shall consider the following:

    1. The usual remuneration of services or treatment;
    2. Impact upon cost to employers; and
    3. Impact upon cost to the health care system."

  The current three member Workers' Compensation Panel for review of physicians' fees was changed so it is now composed of the Insurance Commissioner; replacements appointed by the Governor, one representing labor and the other representing business.

Other Health Legislation Passed by the 1983 Legislature:

- Revision of Chapter 154, F.S., which establishes county health departments (HB 238).
- Allows chiropractors and podiatrists to refer patients to physical therapists (HB 286).
- Revises regulations regarding bicycle safety (HB 225).
- Authorizes school personnel to assist students with prescription medication (HB 463).
- Requires public food service establishments to familiarize employees with procedures to assist choking victims (HB 530).
- Requires self-insurance programs for health care to make available provisions for chiropractic care (optional rider or endorsement) (HB 487).
- Authorizes hospital pharmacies to establish institutional formularies with the approval of the medical staff (HB 676).
- Substantially revises anatomical gift program to set up procedures for identification of donors on drivers' licenses (SB 954).
- Reenacts (pursuant to Sunset) regulation of drug abuse treatment programs (HB 1075).
- Provides that outpatient treatment insurance coverage for mental and nervous disorders, which may be limited to $1,000, applies to licensed physicians, licensed psychologists, and mental health professionals (HB 1159).
- Reenacts certification requirements for emergency medical services personnel. Requires the Department of Health and Rehabilitative Services to contract with the Department of Professional Regulation for certain services related to certification (HB 1165).
- Revises Florida's HMO Law to require actuarial soundness for the benefits provided. Gives the Department of Insurance greater power to protect patients from insolvency of HMOs.
- Establishes a Board of Hearing Aid Specialists within the Department of Professional Regulation. Retains otolaryngologist on board (SB 302).
- Allows patients and their representatives to obtain medical records from physicians and hospitals pursuant to subpoena (HB 1127).

Other Major Objectives of the FMA, as of This Date, for the 1984 Session of the Legislature Are:

- Opposition to authorization for pharmacist "health care consultants" to prescribe directly to patients without physician examination or diagnosis.
- Opposition to legislation mandating hospital staff privileges to nurse anesthetists.
- Opposition to proposals increasing the regulation of office personnel taking x-rays.
- Opposition to licensure of lay midwives.
- Opposition to use and prescription of drugs by optometrists.
- Opposition to elimination of confidentiality of medical staff meeting records.
- Opposition to legislation giving chiropractors access to hospital outpatient diagnostic facilities.
- Support for hazardous waste monitoring.
- Support for legislation increasing the drinking age to 21.
- Support for increased funding for medical services for the indigent.

A supplemental report will be prepared by the Committee on State Legislation and distributed prior to the first session of the House of Delegates. This supplemental report will outline up-to-date progress of the FMA legislative program made during the 1984 Legislative Session. It will also include other important state legislative items which might develop prior to the FMA Annual Meeting.

Supplemental Report
Council on Legislation

The Supplemental Report of the Council on Legislation was adopted.

The Committee reported to the House of Delegates, as information, that it strongly opposes any changes in the present Medical Practice Act of the Florida Statutes, 1983.

Supplemental Report
Council on Legislation
Louis C. Murray, M.D., Chairman

This is to update the report of the Council on Legislation printed in the *Delegates' Handbook*. This report reflects the status of legislation as of April 23, 1984.

1. **Professional Liability and Tort Reform Proposals**

   The FMA's tort reform package has been introduced in both the House and the Senate. (HB 1055, SB 835). Committee hearings on these bills have not been scheduled as of this date. The elements of the FMA bill are:

   - Limitation on general damages of $100,000;
   - Elimination of the doctrine of joint and several liability;
   - Strengthening of summary judgment procedure.

   Several other tort reform bills have been introduced (all but one still reside in the committees of reference). These include:

   - A proposal passed by the House Commerce Committee (HB 522, SB 607), which endorses the following provisions:

- Requirement for the SBME and hospital staffs to review physicians having two or more paid claims in a previous five-year period;
- Additional protections for hospital peer review committees;
- Tightens up standards for expert witnesses;
- Mandatory structured payments for future awards over $1 million;
- Voluntary arbitration and a 90-day "cooling off" period;
- Repeal of recovery of costs statute.

- Limits recovery against state medical schools to $100,000 per claim ($200,000 for multiple claims for same incident) (HB 612, SB 901);
- Proposal similar to the bill passed by the Florida Senate in 1983 (HB 1101, SB 840);
- Disciplinary sections contained in HB 522:

  - Requirement for evidence of punitive damages before the court allows this to be amended into pleading of plaintiff;
  - Mandatory structured payments for future damages in excess of $200,000;
  - General damage limitation on $250,000;
  - Elimination of the doctrine of joint and several liability;
  - Protections for peer review committees.

- Abolishment of doctrine of joint and several liability, (SB 633).
- Proposals containing the provisions of SB 840 and HB 1011, except:

  - No general damage limitation;
  - Mandatory insurance of $150,000 per claim as conditions for licensure as M.D. or Osteopath;

- Strengthening requirements for expert witness to require teaching or practice experience within Florida and the specialty of defendant (SB 902);
- Abolishment of joint and several liability (SB 970);
- Requires permission of court to plead punitive damages. Any recovery is apportioned as follows:

  - 20% to plaintiff's attorney and 80% to the state for the care of indigents (SB 971).

- Limitation of general damages to two times the amount awarded for noneconomic damages (SB 1015);
- A proposal containing the provisions of SB 1015, SB 970, and SB 971 and mandatory structured payments for future damages in excess of $200,000 into one bill (SB 1022).

2. **Other Key Issues Contained in FMA's 1984 Legislative Program and Outlined in the Delegates' Handbook.**

- Opposition to authorization for pharmacist "health-care consultants" to prescribe directly to patients without physician examination or diagnosis (SB 45, HB 104). SB 45 is in Senate Economic, Community and Consumer Affairs Committee. HB 104 is in House Appropriations Committee.
- Opposition to legislation mandating hospital staff privileges to nurse anesthetists (SB 386, HB 620). SB 386 was defeated in Senate HRS Committee. HB 620 was defeated in House HRS Committee.
- Opposition to proposals increasing the regulation of office personnel taking x-rays (PCB 42, SB 242). PCB 42 will be renumbered and referred at a later date. SB 242 is in Senate HRS.
- Opposition to licensure of lay midwives (SB 231, HB 342). SB 231 is in Senate HRS. HB 342 is in House Appropriations.
- Opposition to use and prescription of drugs by optometrists. No bill has been filed in either House.
- Opposition to elimination of confidentiality of medical staff meeting records. This concept is in the House Judiciary Committee.
- Opposition to legislation giving chiropractors access to hospital outpatient diagnostic facilities. No bill has been filed in either House.
- Support for legislation increasing the drinking age to 21 (SB 51, HB 21). SB 51 is in the Senate Commerce Committee. HB 21 defeated by the House Regulated Industries Committee.
- Support for hazardous waste monitoring. Several proposals have been filed in the House and the Senate.

- Support for increased funding for medical services for the indigent. Several concepts are provisions contained in cost containment legislation.
- Support for expanding coverage for newborn children in health insurance policies to include the newborn child of a family member of the insured or subscriber (SB 682, HB 260). SB 682 is in Senate Commerce Committee. HB 260 is in House Appropriations Committee.
- Support for the removal of the prohibition against individuals affiliated with a medical school from serving on the State Board of Medical Examiners (SB 341, HB 1011). SB 341 is in Senate HRS Committee. HB 1011 is in House Finance and Taxation Committee.

- Support for the authorization or licensure of osteopathic physicians by the Florida Board of Osteopathic Medical Examiners (SB 341, HB 1011). SB 341 is in Senate HRS Committee. HB 1011 is in House Finance and Taxation Committee.
- Opposition to legislation requiring hospitals and ambulatory surgical centers to maintain and update records on elective surgery. No bill has been filed in either House.
- Opposition to legislation removing the exemption from the Open Records Law of complaints against regulated professionals regardless of whether or not probable cause is found (PCB 29). PCB 29 is in the House Judiciary Committee.

- Opposition to legislation creating a licensure statute for respiratory therapist (CS/HB 775, SB 881). CS/HB 775, which creates a certification statute for respiratory therapists, is in the House Finance and Taxation Committee. SB 881 is in the Senate Economic, Community and Consumer Affairs Committee.
- Opposition to legislation mandating the summary of treatment alternatives for breast cancer (CS/SB 157, CS/HB 279/462). CS/SB 157 is in Senate Judiciary-Civil Committee. CS/HB 279/462 is in House HRS Committee.
- Opposition to legislation requiring that all health insurers provide a "finder's fee" to individuals who discover an overcharge in their health insurance policies (HB 179). HB 179 has been withdrawn.

- Opposition to legislation requiring the directed donation of blood by a donor to a patient who is a relative (HB 241). HB 241 is in House HRS Committee.
- Opposition to reducing the amount of time a medical faculty certificate in lieu of a Florida license to practice medicine is in effect (HB 1011, SB 341). HB 1011 is in House Finance and Tax Committee. SB 341 is in Senate HRS Committee.
- Opposition to legislation mandating state regulation of hospital rates or budgets (CS/SB 176/697, CS/HB 506/

965). CS/SB 176/697 is in Senate Commerce Committee. CS/HB 506/965 is in House Appropriations Committee.

Additional Major Health Legislation Filed

a. **Hospital Staff Privileges for Psychologists, Lay Midwives, and Nurse Practitioners (SB 277, SB 407, HB 565, and HB 418).** SB 277 was defeated in the Senate HRS Committee. SB 407 is in the Senate HRS Committee. HB 565 is in the House HRS Committee. HB 418 is in the House HRS Committee.

b. **Certification of Medical Assistants (SB 97).** Provides for statutory recognition for medical assistants who perform certain duties in a physician's office. Certification is optional. SB 97 is in the Senate HRS Committee.

c. **Mandatory Chiropractic Insurance Coverage (SB 279, HB 475).** Requires health insurance policies to provide coverage for chiropractic services. SB 279 is in Senate Commerce Committee. HB 475 is on the House Calendar.

d. **Mandatory Second Surgical Opinions (HB 894).** Provides for mandatory second surgical opinions for specific procedures. HB 894 was defeated in House Commerce Committee.

e. **Physician's Staff Privileges (SB 460).** Provides a licensed facility may not deny an application of physician for staff membership or clinical privileges when such facility maintains an average annual occupancy level of less than 75 percent. SB 460 is in Senate HRS Committee.

f. **School Health Services Act (SB 272, HB 325).** Provides for amendment to School Health Services Act. The proposed statutory authorization for such examinations by chiropractors was deleted. SB 272 is in Senate Appropriations Committee. HB 325 is on House Calendar.

g. **Advertising Free Services (SB 515, HB 837).** Provides that any health care provider who advertises a free service and then charges for it is subject to disciplinary action by the appropriate licensing board. SB 515 is in Economic, Community and Consumer Affairs Committee. HB 837 is in House HRS Committee.

h. **Certificate of Need (SB 331, HB 201).** Provides that in administrative proceedings or judicial review relative to CON appeals, that only events, circumstances or conditions upon which the Department made its decision shall be admissible in the appeal process. Evidence that was in existence at the time the Department made its decision would be admissible. SB 331 is in Senate Judiciary-Civil Committee. HB 201 is on House Calendar.

i. **Anabolic Hormones (SB 35, HB 997).** Provides certain restrictions on prescription or administration of anabolic hormones. SB 35 is on the Senate Calendar. HB 997 was defeated in House Regulatory Reform Committee.

j. **Right to Die (SB 343, CS/CS/HB 127).** Allows any competent adult to make a written declaration directing the withholding of life prolonging procedures in the event such person has a terminal medical condition. Allows the patient's spouse, a court appointed guardian, and others to make such a decision if the person is incapable of communication and has not made such a declaration. Provides immunity from liability for the physician. SB 343 is in Senate Judiciary-Civil Committee. CS/CS/HB 127 is in House Appropriations Committee.

k. **Prepaid Health Care (SB 342, HB 850).** Provides for separation of the regulation of health maintenance organizations and prepaid health clinics. Defines health maintenance organizations as those providing inpatient hospital services and health clinics and those providing emergency care, ambulatory diagnostic treatment or physician services other than hospital inpatient services. Provides for the regulation of prepaid clinics by the Department of Insurance. SB 342 is in Senate HRS Committee. HB 850 is in House HRS Committee.

l. **Alzheimer's Disease (CS/HB 417, SB 508).** Appropriates $900,000 to DHRS to establish memory disorder clinics and related day care programs for persons suffering from Alzheimer's Disease and related disorders. CS/HB 417 is in House Appropriations Committee. SB 508 is in Senate Appropriations Committee.

m. **Maternal Deaths (CS/SB 38, HB 964).** Requires a death certificate to state whether or not the death is a maternal death; authorizes the Health Program Office of DHRS to investigate all reported maternal deaths. CS/SB 38 is on Senate Calendar. HB 964 is on Senate Calendar.

n. **Birthing Centers (SB 782, HB 1049).** Provides for the licensing and regulation of birth centers (a faculty which is not an ambulatory surgical center or hospital, where births are planned to occur away from the mother's usual residence) by the DHRS; requires client education and orientation; provides for prenatal care; limits surgical services; provides for laboratory services and postpartum care. SB 782 is in Senate HRS Committee. HB 1049 is in House Finance and Taxation Committee.

Other Late Developing Legislative Activities

1. **Radiologic Technologist.** Legislation relating to the certification of radiologic technologists is being debated in the Florida Legislature. SB 242 reenacts the current radiologic technologist law and is in the Senate HRS Committee. HB 1231 has passed the House Regulatory Reform Committee and in its present form poses several areas of concern that merit attention. A general description of HB 1231 and several issues raised are as follows:

   - The bill requires all personnel, except persons licensed to practice medicine, podiatry, chiropody, osteopathy, naturopathy or chiropractic; or licensed to provide clinical laboratory services who use radiation emitting equipment in a hospital to be licensed radiologic technologists. It establishes three categories of technologists:

     a. **General radiographer** — may perform only diagnostic radiographic and NMR studies.
     b. **Radiation therapy technologist** — may administer only x-radiation and ionizing radiation emitted from particle accelerators and sealed sources of radioactive material for therapeutic or simulation purposes.
     c. **Nuclear medicine technologist** — may only (a) conduct in vivo and in vitro measurement of radioactivity; (b) administer radiopharmaceuticals for diagnostic and therapeutic purposes; and (c) perform NMR studies excluding radioimmunoassay and other clinical laboratory testing pursuant to Chapter 483, F.S.

     Exceptions to these requirements are:

     a. Hospitals of less than 100 beds can use the basic x-ray machine operator, provided the hospital has only general diagnostic radiographic machinery and fluoroscopic equipment.
     b. Basic certificate holders can get a general radiographer's certificate if, on October 1, 1984, they are employed by a hospital and can demonstrate competency to the satisfaction of the Department of Health and Rehabilitative Services.

Issues Raised for Hospital-Based Services

a. The limited license for computed tomography technologists is phased out.
b. A radiation therapy technologist and a nuclear medicine technologist cannot be used for functions performed by a general radiographer (no cross-utilization).
c. The bill is written to conform to the general standards of operation in a large full service hospital. It would:

1. Not allow smaller hospitals to use non-licensed radiologic technologists for diagnostic services if the hospital owns equipment other than general diagnostic radiographic machinery or fluoroscopic equipment.
2. Not allow general radiographer to be trained by hospital to do routine nuclear scans, such as, GI bleeding, brain, profusion lung, liver/spleen, hida or gall bladder and bone scans.
3. Not allow RNs to give in-service training or less than 24 month radiologic technologist training to use any radiation emitting equipment.

Issues Raised for Physician Offices

a. The exclusion of iodinated contrast materials used in a physician's office appears contradictory to the intent of the Radiologic Technologists law which is to protect the x-ray machine operator from the harmful effects of radiation.

The Council on Legislation asks for permission to introduce to the Reference Committee any item of major significance that might have arisen in the Legislature between April 25 and the time of the FMA Annual Meeting.

RESOLUTION 84-2
Insanity Plea
Lee County Medical Society

Resolution 84-2 was adopted.

RESOLUTION 84-2
Insanity Plea

RESOLVED, That the FMA use its influence to have introduced and passed in the Florida Legislature a bill which would:

1. Not allow insanity to be used as a defense in a criminal trial. The guilt or innocence would be determined solely on the facts of the case.
2. The sanity of the defendant could be raised as an issue to be considered in the pre-sentence investigation and if necessary, a pre-sentence hearing.
3. Then, after a determination of the defendant's insanity, the Judge can use this determination in the sentencing.
4. The defendant could be sentenced to a psychiatric hospital until treatment is completed and then complete his sentence in prison.

RESOLUTION 84-4
Occupational Licenses
Dade County Medical Association

The motion of the Reference Committee that Resolution 84-4 be referred to the Board of Governors carried.

RESOLUTION 84-4
Occupational Licenses

(Not adopted — Referred to Board of Governors)

Whereas, The state of Florida is among several states where there is evidence of widespread use of fraudulent medical credentials by persons posing as physicians; and

Whereas, The practice of medicine by untrained persons using bogus credentials is a serious threat to the safety of the public; now therefore be it

RESOLVED, That the Florida Medical Association sponsor statewide legislation which would require all counties and municipalities in Florida to examine and validate a current and active state medical license before issuing a local occupational license to any physician who seeks to maintain an office for the practice of medicine.

RESOLUTION 84-14
Florida Medical Association
Responsibility to Quality of Life Legislation
Volusia County Medical Society

The motion of the Reference Committee that Resolution 84-14 be referred to the Board of Governors carried.

RESOLUTION 84-14
Florida Medical Association
Responsibility of Quality of Life Legislation

(Not adopted — Referred to Board of Governors)

Whereas, The Florida Medical Association has an obligation to the people of the state of Florida in a broad range of health-related areas; and

Whereas, The Florida Medical Association is an active, political organization; and

Whereas, Many Florida legislators perceive the Florida Medical Association as being involved only in those areas which have a financial impact to the physicians of the state of Florida; now therefore be it

RESOLVED, That the Florida Medical Association be instructed to utilize its political influence and become involved in legislation which indirectly as well as directly affects the quality of life for the people of the state of Florida.

The Chairman expressed deep appreciation on behalf of the Committee to FMA staff, Mr. Donald S. Fraser Jr., Donald W. Weidner, Esq., and Ms. Julie Woodman for their assistance in the preparation of this report. The Committee also thanked all members of the Florida Medical Association who appeared before the Committee, as well as the members of the Committee, Dr. John H. Parker Jr.; Dr. Virgil A. Ponzoli Jr.; Dr. Jesse Q. Sewell III; Dr. Ernest G. Sayfie; Dr. Richard H. Ciordia, Alternate; Dr. Louis C. Murray, AMA Delegate Advisor; and Dr. Frank C. Coleman, AMA Alternate Advisor.

The motion of the Reference Committee that the Report of Reference Committee No. IV be adopted as amended carried.

EMERGENCY RESOLUTION

DeSoto-Hardee-Glades County Medical Society

A motion from the floor carried to adopt an Emergency Resolution as presented by Dr. Calvin W. Martin of the DeSoto-Hardee-Glades County Medical Society.

EMERGENCY RESOLUTION

Whereas, Doctors of Medicine are honorable citizens; and

Whereas, Their chief tenets are honesty and credibility; and

Whereas, A small number of physicians have demonstrated their lack of these attributes by failing to honor just debts or obligations such as federal grants, loans or pledges of public service; therefore, be it

RESOLVED, That the FMA disavow these offenders and use its influence to help assure restitution; and further, be it

RESOLVED, That the FMA go on record as encouraging the U.S. Government to use all legal means to recover these bad debts.



The Council on Scientific Activities and leadership from Florida's Colleges of Medicine meet annually at the Dean's Luncheon. Left to right: FMA President J. Lee Dockery, M.D., Gainesville; Robert C. Fore, Ed.D., FMA Director of Scientific Activities; James A. Hallock, M.D., Associate Dean of the University of South Florida College of Medicine, Tampa; Calvin W. Martin, M.D., Chairman, FMA Committee on Medical Education, Arcadia; William B. Deal, M.D., Dean of the University of Florida College of Medicine, Gainesville; and Henry M. Yonge, M.D., Chairman of the FMA Council on Scientific Activities, Pensacola.

Dr. Perry recognized the President, Dr. J. Lee Dockery, and asked that he come forward to install the new President.

Dr. Dockery presented the personal gavel, the President's Plaque and the book entitled "Familiar Medical Quotations" to Dr. Frank C. Coleman, the new President of the Florida Medical Association, Inc.

Dr. Coleman in turn presented Dr. Dockery with the Past President's Pin, the new Past President's green blazer and gold cufflinks which have the same emblem as the Past President's Pin.

Dr. Coleman then asked Mrs. Dockery, escorted by her children, Michael, Kim and Laura, to come to the platform for presentation of Dr. Dockery's portrait.

Remarks — Frank C. Coleman, M.D., President

In his book, *Megatrends*, John Naisbitt says that change occurs when there is a confluence of both changing values and economic necessity, not before, and we as physicians certainly are in a time of great change — a change that is so dramatic and so sudden that it has dazzled many of us. It is clear that changing values and economic necessity are primarily responsible for this change.

This change is affecting physicians and the way they practice; hospitals and the way they operate; businesses and the way they provide health benefits to their employees; and government and the way it provides health care for a large segment of our population.

Physicians, particularly the younger ones, are finding and creating many new ways to practice. Many physicians going into practice for the first time find that residual debt, high interest rates, the cost of medical equipment and professional liability insurance make it almost impossible to open a private office.

Many of them are choosing alternatives such as open freestanding surgery centers, walk-in clinics and urgent care centers. They are signing on with HMOs and PPOs, and many of them are finding that employment is an attractive alternative to independent practice. They may become employees of a physician group, a corporation or a hospital. Some 140,000 physicians now have contractual relationships with hospitals.

Hospitals are faced with competition from freestanding walk-in clinics and other forms of care that used to be available only in hospital emergency rooms or outpatient departments. Hospitals are fighting back by forming their own satellite clinics, frequently in competition with their own medical staff. They are cooperating with HMOs and PPOs. They are forming and joining chains, both non-profit and for-profit, and they are looking for new kinds of revenues, often in non-health related fields.

What about patients? They are beginning to change, too. They are discovering freestanding centers. They are finding that it is frequently no longer necessary for them to call a physician for an appointment. They are walking into these centers and being taken care of without appointments. They are also finding that their health insurance benefits are not what they used to be. Many of them are being reduced so the patients have to pay more of the bill. Some of them are limited in their choice of physician and hospital if they want to receive full benefits. This means a new and very personal interest in what is done for them and what it costs.

What about businesses? They are setting up their own PPOs, changing their health benefits packages for their employees, and developing lists of fee schedules of physicians and charges of hospitals which they can provide to their employees.

What about government? Government is now reneging on its commitment to the elderly, the poor and the disabled — a commitment which 30 years ago guaranteed them health care as a right. The cost of Medicare and Medicaid has forced the government to this position. The government has imposed the prospective payment system on hospitals in an effort to control costs, and it may very well do the same for physicians.

There is increasing discussion about rationing of care and the ethical problems involved in the care of the terminally ill. One out of every three Florida physicians will have a malpractice claim filed against him this year.

In spite of all these changes, I believe that we should take the positive view and remember that our obligation as physicians, just as it always has been, is to provide quality medical care regardless of the changing times. This is a sacred trust and must be defended with all of our strength.

The House of Medicine must make whatever adjustments should be made to defend this trust. The roof covering the House of Medicine must be broad enough for every physician to participate in the decision-making process of the Florida Medical Association and in the implementation of these decisions.

The theme of my administration as President during this coming year will be: **One Profession — One Association — One Future.**

One Profession: No matter what specialty we are, no matter what our mode of practice, we are all physicians first. We must work to further the best interests of that profession, knowing that none of us can succeed unless the profession succeeds.

One Association: The state association, in cooperation with all of the county and specialty organizations, must have unity and represent all physicians. It must have programs, projects, policies and a philosophy that meet the needs and further the goals of all physicians regardless of their individual attributes and circumstances.

One Future: What happens to any of us happens to all of us. Some physicians cannot succeed while others fail. We all succeed together as physicians or we all fail. Whatever differences exist, our response to problems of the future — legislative, economic, professional, scientific — must be focused toward the needs of all.



President-Elect Frank C. Coleman, M.D. and Mrs. Coleman (Ruth) pose for the camera at the Annual President's Reception.

Change of Command


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One of the highlights of the third session of the House of Delegates was the installation of the new President, Frank C. Coleman, M.D., and recognition of the many contributions of Immediate Past President, J. Lee Dockery, M.D. (1) Immediate Past President J. Lee Dockery, M.D. proudly receives the honored Past President's Coat and Pin from President Frank C. Coleman, M.D. (2) According to tradition, the large portrait of the President of the FMA which has been hanging in the lobby of the FMA Headquarters office for the past year is presented to the President's wife at the annual meeting. President Frank C. Coleman, M.D., presents the portrait to Mrs. J. Lee (Barbara) Dockery as Immediate Past President J. Lee Dockery, M.D. looks on. (3) Outgoing President J. Lee Dockery, M.D., passes the gavel and congratulates President Frank C. Coleman, M.D. (4) President Frank C. Coleman, M.D. receives a standing ovation as he prepares to deliver his Presidential Address.

Report of Reference Committee No. V Medical Economics

Dr. Perry called the Chairman and members of Reference Committee No. V, Medical Economics, to present their report.

Dr. Robert H. Hux, Chairman, and his committee came forward to present the report of Reference Committee No. V, Medical Economics.

Report E of the Board of Governors

The Reference Committee considered Report E of the Board of Governors and Resolution 84-12, Second Opinion Requirements, together because of similar subject matter and offered a substitute for Resolution 84-12. The motion carried to adopt Report E of the Board of Governors and Substitute Resolution 84-12.

Report E of the Board of Governors

J. Lee Dockery, M.D., Chairman

House of Delegates Referrals

SUBSTITUTE RESOLUTION 83-7
Workers' Compensation Medical Fee Schedule

The resolution below was adopted in lieu of Resolution 83-7, Dade County Medical Association, and Resolution 83-14, Palm Beach County Medical Society:

RESOLVED, That the FMA continue its efforts to obtain equitable fee differentials throughout the state and that the fees sought be equivalent to the usual and customary fees charged in the various communities; and be it further

RESOLVED, That if FMA is unsuccessful in achieving fee differentials under its present course of action, the FMA seriously study the possibility of litigation which would eliminate the present Workers' Compensation Medical Fee Schedule and instead provide reimbursement based upon usual and customary charges for such services as is done in 33 states; and be it further

RESOLVED, That FMA support the concept of regional differentials Workers' Compensation fee schedules for physicians practicing medicine in counties where the cost of living is higher than the average for the state of Florida.

The activities of the Committee on Workers' Compensation, in implementing this resolution, are outlined in the Annual Report of the Council on Medical Economics.

Cost of Practicing Medicine Survey: The Board approved conducting a survey to determine the cost of practicing medicine in various regions in the state of Florida to assist in the implementation of Substitute Resolution 83-7 adopted by the FMA House of Delegates at its meeting in May 1983.

Physician Services: The Board approved the following actions to be taken if the Workers' Compensation Three-Member Panel reduces the physician fee schedule to the 50th percentile of the Division of Workers' Compensation Data Base:

1. Request a hearing under the Administrative Hearing Act once the Workers' Compensation Physicians' Fee Schedule is promulgated as a rule.
2. Authorize the presentation of testimony at the hearing challenging (1) the validity of the data base used by the Three-Member Panel, and (2) the use of the 50th percentile for establishing the 1984 fee schedule.
3. If the results of the hearing are unacceptable, file suit against the Division of Workers' Compensation, if legally reasonable.

Medical Consultants: The Board requested nominations from FMA recognized specialty groups of the names of physicians to be submitted to the Workers' Compensation Three-Member Panel for approval as consultants to the office of Medical Services Division of Workers' Compensation. It was felt that the appointment of these consultants would be of assistance in helping to curb the alleged problem of questionable billing practices on the part of some physicians.

Medical Director: The Board reaffirmed the Association's continued efforts to seek the appointment of a physician as medical director to the Division of Workers' Compensation.

FMA Councils and Committees

COUNCIL ON MEDICAL ECONOMICS

PMUR: The Board approved the Florida Medical Foundation's revised operating procedures for conducting the peer medical utilization review program for Medicare and Medicaid and plans for implementation of the program including the letter of understanding with the county medical societies.

Statewide PRO: The Board reaffirmed the previous action of the House of Delegates in May 1983 authorizing the FMA, through the Florida Medical Foundation or other approprite entity, to apply for designation as a statewide PRO for the state of Florida. The Board further directed the concept that the activities of the statewide PRO be implemented through a single state organizational structure with branch offices throughout Florida in cooperation and coordination with component county medical societies.

PRO Board of Directors: The Board approved appointment of subscribing members to the FMF/PRO Board of Directors in accordance with the actions taken by the Board at its meeting in October 1983 that composition of the Board include five members appointed by the FMA and two members by the Florida Osteopathic Medical Association and that the additional appointments to the Board of Directors of four physician members (one elected from each FMA medical district or PRO districts that may be created) be considered by the subscribing members of the PRO Board at the appropriate time subject to approval by the FMA Board of Governors.

The subscribing members of the PRO Board and acting officers as well as additional information regarding establishment of the PRO proposal is outlined in the Report of the Council on Medical Economics included in this section of the *Delegates' Handbook*.

Uniform Health Insurance Policies: The Board approved a proposal that health insurers should be required to reimburse physicians for all procedures that the attending physician determines can be safely and appropriately performed on an outpatient basis but are currently being reimbursed only on an inpatient basis.

Hospital Cost Containment Board: The Board reaffirmed the FMA's continued opposition to the submission of physicians' charge data to the Hospital Cost Containment Board.

Second Opinions: The Board expressed continued opposition to mandatory second opinions and reaffirmed the position that second opinions for elective surgery should be at the option of the patient.

Hospital User Fees: The Board expressed continued opposition to a physician user fee for the use of hospital equipment and services as such an expense would have to be passed on to the patients and would cause additional costs to hospitals for record keeping and reports.

Certificate of Need: The Board reaffirmed opposition to the Certificate of Need laws as well as any reinstatement of authority over the CON Program by local health councils and requested the Council on Legislation to support efforts to eliminate funding for CON activities by local health councils. The Board also recommended that the American Medical Association intensify its efforts to defeat the national health planning legislation now being considered by Congress.

(SB 216) Group Health Insurance Plan: The Board determined to seek repeal of SB 216 enacted during the 1983 Legislative Session which allows for participants in a government group health insurance program who discover that they are overcharged by a hospital, physician, clinical lab and other health care providers to receive a refund of 50 percent of any amount recovered as a result of such overcharge up to a maximum of $1,000 per admission.

DRG Educational Seminars: The Board authorized the FMA to participate in the prospective pricing system (DRGs) seminars being sponsored by the American Association of Retired Persons, Blue Cross and Blue Shield of Florida of Florida, the Florida Hospital Association, the Florida Council on Aging, and the State Insurance Commissioner's Office.

Meeting with Florida Business Leaders: The Board authorized the President and other appropriate FMA representatives to meet with prominent business leaders in Florida to establish an ongoing relationship for addressing health care issues of mutual interest.

Uniform Informed Consent Form: The Board approved the uniform informed consent form as developed by the Council on Medical Economics in cooperation with the Florida Hospital Association and determined that a copy of this form be disseminated to county medical societies with an explanation that it is important for the potential users to recognize that while it has been developed as a uniform informed consent form, it is not necessarily more desirable than the one they are currently using, and that they may wish to have it reviewed by their own legal counsel (included as Appendix 1 to Report E of the Board of Governors in the *Delegates' Handbook)*.

HMOs: The Board of Governors discussed in-depth the concerns expressed by numerous FMA component county medical societies regarding the proliferation and marketing activities by HMOs throughout the state. The Board also reviewed a comprehensive report on the status of HMOs in Florida prepared by the Council on Medical Economics following an extensive study. (This report is included for the delegates' information as Appendix 2 to Report E of the Board of Governors in the *Delegates' Notebook)*.



Reference Committee V (Medical Economics) was chaired by Robert H. Hux, M.D., Leesburg. Left to right: Samuel Atkinson, M.D., Ft. Walton Beach; Lee A. Fischer, M.D., West Palm Beach; Ms. Donna Marlow, Recorder; Dr. Hux; Wayne L. Godbold, M.D., Winter Garden; S. Peter Stokley, M.D., South Miami; and Thomas M. Caswall, M.D., Bartow.

The Board has authorized the dissemination of an informational brochure on HMOs and other alternative health care delivery mechanisms to suggest questions that patients should ask and have answered before participating in one of these health care delivery mechanisms. The brochures will be made available to county medical societies for distribution to physicians' offices upon request.

The Board further determined that a central informational source on HMOs, IPAs, PPOs, etc., be established in the FMA Headquarters Office.

RESOLUTION 84-12
Second Opinion Requirements
Polk County Medical Association

A substitute for Resolution 84-12 was offered by the Reference Committee and its adoption moved. The motion carried and Substitute Resolution 84-12 was adopted.

SUBSTITUTE RESOLUTION 84-12
Second Opinion Requirements

RESOLVED, That representatives of the Florida Medical Association meet with appropriate representatives of the insurance industry for the purpose of delineating guidelines with physicians of Florida on second opinions and these guidelines established should in no way restrict the patient's freedom of choice in choosing who should render the second opinion and who shall provide the proposed care.

Report of the Council on Medical Economics

Lengthy discussion was heard by the Reference Committee regarding the report of the Committee on Worker's Compensation and moved to amend the report of the Committee on Worker's Compensation by striking the words "the 90th percentile or" in the first paragraph and substituting the word "fee" after the word "customary." The motion carried.

The report of the Council on Medical Economics was adopted as amended.

Council on Medical Economics
Charles P. Hayes Jr., M.D., Chairman

The Council on Medical Economics has faced many issues this year as a result of an ever-increasing interest on the part of government and the public in the financing of health and medical care. It is still too early to determine the effects that the DRG Prospective Payment System will have on Florida hospitals, physicians, and most importantly, the care of their patients. No one knows where the new competitive forces in health care delivery will lead our profession. Government is implementing "cost containment" programs and legislation while at the same time mandating more costly treatment modalities such as organ transplants. One thing is certain, and that is the environment in which we find ourselves is rapidly changing.

The typical physicians' income over the last ten years has risen less than inflation while his practice expenses are rising faster. His professional liability insurance premiums also exceed the overall rate of increase in practice expense with no relief in sight.

Many young physicians completing their training are experiencing difficulty in establishing private practices and thus an increasing number of them are joining group practice and in some cases, HMOs freestanding clinics.

The Council on Medical Economics, including its committees, have been discussing the rapid changes in our professional environment and are developing recommendations for FMA positions.

The following is a summary of their activities during the past year:

Committee on Health Care Financing

The Committee on Health Care Financing, chaired by William J. Garoni, M.D., has observed the implementation of the Prospective Payment System in Florida (DRGs) and has developed the following guidelines for physicians:

- Medical staff members must take the leadership role in preserving and assuring the availability of quality patient care.
- Medical staff members must establish and maintain a perpetual dialogue with the hospital administration and board of trustees to assure that patient needs are considered.
- Physicians should participate in committees for reviewing costs and proposing cost containment initiatives.
- Physicians should be ready to participate in peer review activities in order to bring about the modification of inappropriate practice patterns.
- Physicians should become actively involved in the implementation of DRGs in their respective hospitals.

The Committee, along with the Committee on Government Programs, is continuing to monitor the activities of the "Florida Task Force on Competition and Consumer Choices in Health Care" with special attention to the various proposals on how to resolve the problem of provision of health care to the indigents, which is becoming increasingly severe in Florida, especially with respect to hospital costs. Because of federal DRGs and the plans of the Florida Hospital Cost Containment Board, the "cost shifting" issue is of greater concern to policymakers. The major proposals for resolving the cost shift issue are dependent on adequate funding and broader coverage of the Medicaid Program to include the medically indigent as well as the categorically indigent. The Committee continues to advise that until adequate funding of indigent care is accomplished and the effects of DRGs can be evaluated, it is not in the best interest of our patients for the Legislature to implement a program of hospital rate regulation.

The Committee reconsidered the issue of "second surgical opinions" and advised that such opinions should continue to be at the option of the patient and not mandated. This opinion, along with other issues of importance to physicians and insurance carriers, were discussed in a meeting with the medical directors representing insurance companies who write health insurance policies in Florida.

The Committee has reviewed the current marketing activities of HMOs and PPOs in the state and reports that county medical societies should be aware of what is taking place in their communities regarding HMOs, IPAs and PPOs. Also county

medical societies may want to consider developing an IPA as a means of competing in the market place. The Committee and staff have assisted in the development of an HMO brochure designed to assist patients in understanding what questions they should ask and have answered in writing before joining an HMO.

Committee on Government Programs

The Committee on Government Programs, under the chairmanship of Frank B. Hodnette, M.D., continued to monitor the rules and regulations generated by state and federal agencies of government. The Florida Medicaid Program health care repayment plans have been closely monitored by the Committee. To date, the Medicaid Program has not been able to make much headway with this effort. Another area of concern continues to be the lack of interest on the part of the Governor and the Legislature to increase funding for physicians' fees under Medicaid. The Department of Health and Rehabilitative Services has repeatedly recommended increases, only to have them deleted by the Governor's office. This year, the Department of Health and Rehabilitative Services recommended a $11.2 million increase and the Governor's budget calls for no increase.

The Committee continues its study of the cost of home health care and has contacted the Health Care Financing Administration (HCFA) to determine if there is a way for them to keep physicians informed on the costs of providing this type care for their patients.

Committee on Workers' Compensation

The Committee on Workers' Compensation, under the chairmanship of Howard A. Kurzner, M.D., continues to monitor the activities of the Workers' Compensation Three-Member Panel. In an attempt to implement House of Delegates' Substitute Resolution 83-7, a presentation was made to the Three-Member Panel pointing out the difference between the Division's data at the 75th and 90th percentile as compared to the Blue Cross/Blue Shield Medicare charge data. The Committee's request that the Medicare charge data be used was turned down, and it is anticipated that the Committee's request that physicians be reimbursed at their usual and customary fee by regions of the state will also be turned down. In fact, it has been implied that the Three-member Panel may set the new fee schedule at the 50th percentile of the Workers' Compensation data, which will be a step backwards.

The Committee is concerned that many physicians charge the Workers' Compensation Program only what the current fee schedule allows, rather than their usual and customary charge. Thus, the members of the Three-Member Panel falsely believe that only a few physicians are not satisfied with the level of reimbursement and pay little heed to the Committee's testimony. The Committee is also working to assure that a physician is appointed as the Medical Director for the Division of Workers' Compensation to replace the vacancy left with the resignation of Dr. Ben Johnson.

Committee on Business and Industry Relations

The Committee on Business and Industry Relations, under the chairmanship of William P. Booras, M.D., monitored all coalition activity in the state. The Committee met jointly with the Ad Hoc Committee on the Cost of Health Care and recommended that the President of the FMA meet with the business leaders in the state to develop a working relationship with the business community regarding health care issues of mutual interest. Once again, the Committee encourages county medical societies to become involved early in any coalition activity in their area.

Committee on Relative Value Studies

The Committee on Relative Value Studies, under the chairmanship of Joel W. Mattison, M.D., is currently revising the *1982 Florida Relative Value Studies*. The American Medical Association's *1984 Physicians Current Procedural Terminology, Fourth Edition*, will be used as the basis of the update. It is anticipated that the revision will be completed by September 1984.

Committee on Peer Review Organizations

The Committee on Peer Review Organizations, under the chairmanship of Arthur L. Eberly Jr., M.D., initiated the development of a proposal to the Department of Health and Human Services seeking designation of the Professional Review Organization of Florida, Inc. (PROF) as the statewide Peer Review Organization for Florida pursuant to House of Delegates' Resolution 83-15 and Recommendation No. E-1.

An organizational meeting of the Professional Review Organization of Florida, Inc., was held on February 15, 1984 in Jacksonville. The subscribing members of the PROF are as follows:

Charles P. Hayes Jr., M.D., Jacksonville
Daniel L. Seckinger, M.D., Miami
James D. Morgan, M.D., Winter Haven
Charles E. Cernuda, M.D., Tampa
James M. Potter, M.D., Pensacola
John Hackenberg, D.O., Jacksonville
Perry M. Dworkin, D.O., Miami

Temporary officers were elected in order to expedite the legal aspects of the PROF. Dr. Charles P. Hayes Jr., is serving as the Acting President until the Bylaws are developed and approved. The staff continues to work on completing the PRO proposal for submission to the Health Care Financing Administration by April 27, 1984.

Report of the Florida Medical Foundation — PMUR

The section of the Florida Medical Foundation's Report concerning PMUR was adopted (see Florida Medical Foundation Report, page 596.)

RESOLUTION 84-9
Workers' Compensation
Broward County Medical Association

Upon recommendation of the Reference Committee, Resolution 84-9 was not adopted.

RESOLUTION 84-11
Uniform Medicare Reimbursement Schedule
Capital Medical Society

The motion of the Reference Committee that Resolution 84-11 be referred to the Board of Governors carried.

RESOLUTION 84-11
Uniform Medicare Reimbursement Schedule

(Not adopted — Referred to Board of Governors)

Whereas, An increasing number of patients are moving to North Florida from other areas of our state; and

Whereas, More and more of these patients are questioning the differing reimbursement schedules from the federal government for similar medical services solely dependent upon geographic location of the patient; and

Whereas, Social Security, VA and other similar federal programs are uniform nationwide; and

Whereas, Physicians' fees are under increasing scrutiny by the public at large and by public and private agencies and organizations; therefore be it

RESOLVED, That the Florida Medical Association take all measures necessary to seek a uniform Medicare reimbursement schedule for the state of Florida, and insofar as possible, for the nation as a whole.

RESOLUTION 84-13
Alternative Health Care Delivery Systems
Palm Beach County Medical Society

The Reference Committee moved to amend Resolution 84-13. A motion was then received from the floor to further amend Resolution 84-13 by striking the last "Resolved" and adding the following "Resolveds":

"RESOLVED, That the Florida Medical Association request the State Insurance Commissioner and the Health Care Financing Administration be urged to monitor marketing tactics and enrollment and disenrollment techniques, and also that the Department of Health and Rehabilitative Services and Department of Professional Regulation monitor the quality of medical care of Medicare HMOs; and be it further

RESOLVED, That the Florida Medical Association serve as a clearinghouse for complaints concerning marketing tactics, enrollment and disenrollment procedures, and the quality of medical care, and that any complaints be forwarded to appropriate licensing and regulatory authorities."

The motion to adopt the amendment carried and Resolution 84-13 was adopted as amended.

RESOLUTION 84-13
Alternative Health Care Delivery Systems

RESOLVED, That the Florida Medical Association House of Delegates instruct the Board of Governors to immediately conduct a survey of physicians to determine their ideas, thoughts, and plans concerning health care delivery systems; and be it further

RESOLVED, That the Florida Medical Association House of Delegates instruct the Board of Governors to gather and disseminate information on the changes in the health care delivery system in Florida; and be it further

RESOLVED, That the Florida Medical Association request the State Insurance Commissioner and the Health Care Financing Administration be urged to monitor marketing tactics and enrollment and disenrollment techniques, and also that the Department of Health and Rehabilitative Services and Department of Professional Regulation monitor the quality of medical care of Medicare HMOs; and be it further

RESOLVED, That the Florida Medical Association serve as a clearinghouse for complaints concerning marketing tactics, enrollment and disenrollment procedures, and the quality of medical care, and that any complaints be forwarded to appropriate licensing and regulatory authorities.

The Reference Committee expressed its gratitude to those who appeared before the Committee.

Dr. Hux expressed his appreciation to his Committee consisting of Samuel Atkinson, M.D.; Lee A. Fischer, M.D.; S. Peter Stokley, M.D.; Wayne L. Godbold, M.D.; Thomas M. Caswall, M.D.; and expressed the Committee's appreciation to Charles P. Hayes Jr., M.D., Chairman of the Council on Medical Economics, for his valuable input. The Committee also expressed its appreciation to Philip H. Gilbert, Robert W. Seligson and Ms. Donna Brock of the FMA staff for their able assistance in the preparation of this report.

The motion of the Reference Committee that the Report of Reference Committee No. V be adopted as amended carried.

Election Results

At this time the Speaker advised the members of the House of Delegates of the results of elections held for the offices of President-Elect, Secretary, Vice Speaker, AMA Delegate Seat #2, and AMA Alternate Seat #7 (or #8).

President-Elect

The Speaker announced that Dr. Luis M. Perez had been elected President-Elect.

Secretary

The Speaker announced that Dr. Henry M. Yonge had been elected Secretary. Dr. Dick L. Van Eldik congratulated Dr. Yonge and moved that the House of Delegates give its unanimous support to Dr. Yonge. The motion carried.

AMA Delegate — Seat #2

The Speaker announced that Dr. Joseph T. Ostroski had been elected to AMA Delegate Seat #2 for a term beginning January 1, 1985. Dr. James W. Walker expressed his congratulations to Dr. Ostroski.



The 1984-85 Florida Medical Association Board of Governors poses for the first time after the final session of the House of Delegates. Seated (left to right): Immediate Past President J. Lee Dockery, M.D., Gainesville; Henry M. Yonge, M.D., Secretary, Pensacola; Luis M. Perez, M.D., President-Elect, Sanford; President Frank C. Coleman, M.D, Tampa; James G. White, M.D., Vice President, Ormond Beach; and Yank D. Coble Jr., M.D., Treasurer, Jacksonville. Standing (left to right): FMA Executive Director Donald C. Jones; Speaker of the House James B. Perry, M.D., Ft. Lauderdale; Past President Robert E. Windom, M.D., Sarasota; Gerold L. Schiebler, M.D., Gainesville; T. Byron Thames, M.D., Orlando; Kay K. Hanley, M.D., Clearwater; Charles K. Donegan, M.D., St. Petersburg; Dick L. Van Eldik, M.D, Lake Worth; and Ernest G. Sayfie, M.D., Hollywood.

AMA Alternate — Seat #8

The Speaker announced that Dr. J. Lee Dockery had been elected to AMA Alternate Seat #8. Dr. Lee A. Fischer congratulated Dr. Dockery and moved that the election be by unanimous consent of the House of Delegates. The motion carried.

Speaker of the House
Vice President
Treasurer
AMA Alternate Seat #2
AMA Delegate Seat #3
AMA Alternate Seat #3
AMA Delegate Seat #5
AMA Alternate Seat #5
AMA Delegate Seat #9
AMA Alternate Seat #9
AMA Delegate Seat #10
AMA Alternate Seat #10
AMA Delegate Seat #11
AMA Alternate Seat #11

The Speaker advised that the elections for Vice President, Speaker of the House, Vice Speaker, which was a single nomination, Treasurer and the AMA Delegates and Alternates that were for re-election were unopposed, nominated by acclamation and elected by acclamation.

Vice President — James G. White, M.D.
Speaker of the House — James B. Perry, M.D.
Vice Speaker of the House — Guy T. Selander, M.D.
Treasurer — Yank D. Coble Jr., M.D.

AMA Alternate Seat #2 — James M. Perry, M.D.
AMA Delegate Seat #3 — Charles K. Donegan, M.D.
AMA Alternate Seat #3 — Frank C. Coleman, M.D.
AMA Delegate Seat #5 — Richard G. Connar, M.D.
AMA Alternate Seat #5 — Vernon B. Astler, M.D.
AMA Delegate Seat #9 — Robert E. Windom, M.D.
AMA Alternate Seat #9 — William B. Deal, M.D.
AMA Delegate Seat #10 — Luis M. Perez, M.D.
AMA Alternate Seat #10 — Arthur L. Eberly Jr., M.D.
AMA Delegate Seat #11 — Sanford A. Mullen, M.D.
AMA Alternate Seat #11 — Dick L. Van Eldik, M.D.

The new terms for Delegate Seats 3, 5, 9, 10 and 11 and Alternate Seats 2, 3, 5, 9, 10 and 11 are for two years beginning January 1, 1985 and ending December 31, 1986.

Judicial Council

The Speaker announced that Dr. Kenneth C. Kiehl had been elected by acclamation to the Judicial Council.

Committee on Membership and Discipline

The Speaker announced that the nominees to the Committee on Membership and Discipline as proposed by the Board of Governors had been elected.

District 1: Robert C. Palmer, M.D. (88)
District 2: James T. Cook Jr., M.D. (88)
District 3: John A. Rush, M.D. (88)
District 4: Richard W. Snodgrass, M.D. (88)
District 5: Clarence M. Gilbert, M.D. (88)
District 6: David A. Johnson, M.D. (88)
District 7: William B. Hopkins, M.D. (88)
District 8: John T. Karaphillis, M.D. (88)
District 9: Joseph P. Levine, M.D. (88)
District 10: Wiley E. Koon, M.D. (88)
District 11: John O. Rao, M.D. (88)
District 12: Robert Burger, M.D. (88)
District 13: David L. Thomas, M.D. (88)
District 14: William J. Romanos Jr., M.D. (88)
District 15: Wayne G. Riskin, M.D. (88)
District 16: Nester C. Guaty, M.D. (88)
District 17: Richard C. Clay, M.D. (88)
District 18: Jerome Benson, M.D. (88)
District 19: Rufus K. Broadaway, M.D. (88)

Dr. Perry then recognized Dr. Coleman who announced the members of the Board of Governors who had been either appointed or elected:

FMA Board of Governors

Frank C. Coleman, M.D., President and Chairman
Luis M. Perez, M.D., President-Elect
James G. White, M.D., Vice President
James B. Perry, M.D., Speaker of the House
Henry M. Yonge, M.D., Secretary
Yank D. Coble Jr., M.D., Treasurer
J. Lee Dockery, M.D., Immediate Past President
Robert E. Windom, M.D., Past President
Ernest G. Sayfie, M.D., AL-85
Gerold L. Schiebler, M.D., A-86
Kay K. Hanley, M.D., B-87
Dick L. Van Eldik, M.D., C-85
A. Frederick Schild, M.D., D-88
T. Byron Thames, M.D., FPIR-85
Charles K. Donegan, M.D., AMA-85
Robert N. Webster, M.D., SBME-85
Christopher A. Cunha, Student Member (USF)

The appointment of Council chairmen was also announced:

Council on Legislation — Louis C. Murray, M.D.
Council on Medical Economics — Richard S. Hodes, M.D.
Council on Specialty Medicine — Robert E. Boyett, M.D.
Council on Medical Services — Joseph T. Ostroski, M.D.
Council on Scientific Activities — Pierre J. Bouis Jr., M.D.
Council on Hospital Medical Staffs — T.M. "Dan" Daniel, M.D.
Judicial Council — Joseph H. Davis, M.D.

The Speaker resumed the Chair and proceeded to the benediction which consisted of an innovative slide and sound presentation.

The 1984 House of Delegates adjourned at 11:25 a.m.

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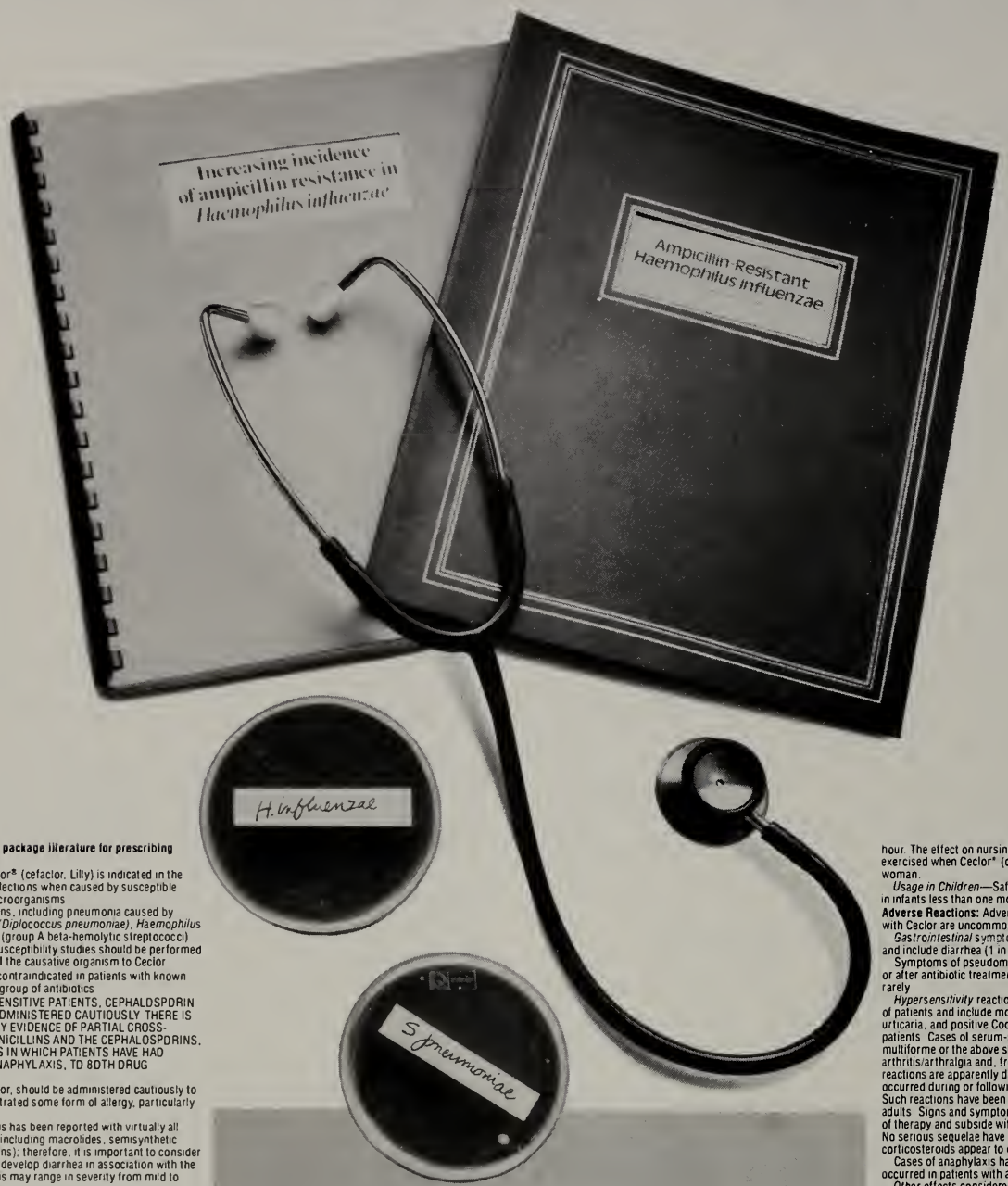
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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus Influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile.* Other causes of colitis should be ruled out

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.15 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae.*[8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975
2. Antimicrob. Agents Chemother., *11*:470, 1977
3. Antimicrob. Agents Chemother., *13*:584, 1978
4. Antimicrob. Agents Chemother., *12*:490, 1977
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II:880. Washington, D.C.: American Society for Microbiology, 1978
6. Antimicrob. Agents Chemother., *13*:861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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FLORIDA MEDICAL
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NOTES & NEWS

Dr. Mixson named President-Elect of ACOG

The American College of Obstetricians and Gynecologists elected William T. Mixson Jr., M.D., of Coral Gables, Florida to the post of president-elect for 1984-85.

A native of Gainesville, Florida, he now serves on the Board of Governors of Doctors' Hospital in Coral Gables. Dr. Mixson has been in private practice in Coral Gables, Florida since 1953.

The noted physician has served his specialty in a variety of ways all his professional life, including President of the South Atlantic Association of OB/GYN and lobbyist for the Florida Medical Association.

Requirements for handicapped parking reviewed

Specific requirements for issuance of handicapped parking permits are not consistently being adhered to according to the Paralyzed Veterans of America. The Florida Statute which contains these requirements (Section 320.0848, F.S.) states that "The Department of Highway Safety and Motor Vehicles shall, upon application, issue an exemption entitlement parking permit to any handicapped person who is currently certified by a physician or an osteopathic physician licensed in the United States, by the Division of Blind Services of the Department of Education, or by the Veterans Administration as being severely physically disabled and having permanent mobility problems which substantially impair his ability to ambulate or who is certified as legally blind."

Medical Advisory Council seeks applicants

Effective October 1, 1984, the State Athletic Commission, Department of Business Regulation, will regulate professional boxing matches in Florida.

Pursuant to Chapter 548, Laws of Florida, the Medical Advisory Council will consist of five members to be appointed by the Governor. The Council shall prepare and submit to the State Athletic Commission standards for physical and mental examination of professional boxers, shall recommend physicians to attend matches, and shall have related duties. Each member shall be licensed to practice medicine in this state and shall, at the time of appointment, have practiced medicine at least five years.

Those physicians who wish to serve on the Medical Advisory Council should direct applications and inquiries to: Gary R. Rutledge, Secretary, Department of Business Regulation, 725 South Bronough Street, Tallahassee, Florida 32301.

JCAH Publishes the 1985 Accreditation Manual

The Joint Commission on Accreditation of Hospitals (JCAH) has announced publication of the 1985 edition of the *Accreditation Manual for Hospitals*. The *Manual*, effective for accreditation decision purposes on January 1, 1985, contains completely revised standards for Medical Staff; Quality Assurance; and Plant, Technology, and Safety Management (PTSM). The PTSM standards replace the "Building and Grounds Safety" and "Functional Safety and Sanitation" chapters in previous editions. This updated edition of the *Manual* features completely revised general administration policies and procedures governing accreditation surveys; fully revised accreditation and appeal procedures; and a new appendix containing standards applicable for surveys in long term care and psychiatric, mental health, and substance abuse facilities that provide acute patient care.

Related publications also available include the 1985 *Hospital Survey Profile* (available in September 1984), *A Guide to JCAH Nursing Services Standards*, the *JCAH Guide to Life Safety*, and the *Safety Clinic Handbook*.

To order the 1985 *Accreditation Manual for Hospitals*, send $40 per copy to: Cashier, JCAH, 875 North Michigan Avenue, Chicago, Illinois 60611. For further information regarding any JCAH publication, telephone the Department of Publications at 312/642-6061.

Congenital defects surveillance project announced

The Congenital Defect Surveillance Project is funded by a grant from the Department of Environmental Regulation. The project began in April, 1984 and the procedures for the project have been established. The objective of the project is to collect data on congenital defects diagnosed during 1980, 1981, 1982, and 1983 for infants less than 1 year of age throughout the state. The purpose is to use the data in assessing the relationship between congenital defects and environmental contaminants, such as ethylene dibromide (EDB). Contracts have been sent to all Florida hospitals with obstetric wards and facilities for treating infants with congenital defects. Abstractors affiliated with the Florida Cancer Data System (FCDS) will conduct the abstracting. The data collection will begin in July, 1984 and should be completed by the end of December, 1984. The analysis will be conducted during the first two months of 1985. Questions should be referred to Mary Kay Falconer in PDHECE at SC 278-2905 or (904) 488-2905.

DEAN'S MESSAGE

Admissions — 1984

Admissions into a college or school of medicine has been the subject of many recent publications in the medical and lay press. Speculation abounds regarding what it takes to "get in" and rumors abound regarding students who have been denied admission. It seems quite appropriate to summarize the status of admissions at both the national level and at the University of South Florida College of Medicine, for the members of the Florida Medical Association.

Each year, the College of Medicine at the University of South Florida receives approximately 1,000 preliminary and formal applications, the majority from bona fide Florida residents. As a state-funded institution, we are dedicated to, and responsible for, training residents of the state for the practice of medicine. As such, of the 1,083 students who have matriculated at the College since its inception in 1971, 1,075 have been residents of the State of Florida.

The process of selecting highly qualified students is performed with considerable care and deliberation taking into account all possible factors. The initial points of evaluation at most schools are the overall and sciences grade-point averages (OGPA and SGPA) combined with performance on the six categories of the New Medical College Admission Test (MCAT). The MCAT tests the six categories of biology (B), chemistry (C), physics (P), science problems (SP), skills analysis reading (SAR) and skills analysis quantitative (SAQ) with scores of 1 - 15 reported in each section.

Although high grade-point averages are important, we look also at course loads, types of courses taken including degree of difficulty, i.e. science vs. non-science; college level at which work is completed, i.e. lower vs. upper division, in evaluating academic performance. Performance in the MCATs are utilized, as recent studies have indicated that there is a good correlation between performance on the MCAT and performance in the basic medical sciences.

For the past several years, the mean OGPA and SGPA of our entering students has been approximately 3.6 on a scale where 4.0 = A. This is slightly above the mean of students accepted nationally. Similarly, the cumulative score on the six categories of the MCAT have been, for the past several years, 58-59 out of a possible 90 which is again at or slightly above the national mean of entering medical students.

Although the importance of these figures may appear somewhat overwhelming, it must be understood that we, as well as most other medical schools, look carefully at other personal factors in selecting medical students. We obviously attempt to strike a balance between cognitive abilities and human qualities in individuals who will become highly competent and empathetic practitioners of medicine. Noncognitive factors such as motivation, maturity, judgement, emotional stability, extracurricular activities, premedical evaluations, and interviews, play an integral role in the consideration given to each applicant.

Over the past fourteen years, competition for entrance to medical schools has undergone several important changes. In the late 1960s and early 70s the number of individuals applying to medical schools increased rapidly. In 1967, there were 21,118 people who applied to the classes beginning in 1968. Six years later there were 42,624 students applying to the 1974-75 entering class. It was also during this time that the number of medical schools increased to 127 from 94 in 1967.

Since 1973, the number of students applying to medical school has been gradually decreasing and has stabilized at approximately 35,000 applicants each year. Today the applicant to acceptance ratio is approximately 1:2, whereas ten years ago it was close to 1:3. Based on these ratios one would assume it is easier now to get accepted to medical school

than it was ten years ago. To the contrary, it is more difficult. In the past, a student possessing marginal credentials had a reasonable chance of gaining acceptance to medical school. Today, this is not the case in as much as successful applicants usually possess a strong B+ to A- average, above average MCAT scores, and above average to outstanding human qualities.

Other changes in admissions trends include the increased numbers of female and non-traditional applicants who are accepted to medical school. There has been a three-fold increase in the female applicant pool from 11.1 percent in the 1970-71 entering class to 32.6 percent in the 1983-84 entering class. Over the past decade, there has been a gradual increase in the number of non-traditional (older) applicants applying and being accepted. These, too, are academically highly qualified individuals who in many instances return to college to demonstrate their continued academic prowess, perform well in the MCAT, apply, and are accepted.

Selection of medical students who will become highly qualified, humane, practitioners of medicine remains an ongoing source of concern and consideration for all medical schools. George Orwell projected a computerized, highly sophisticated, mechanized society of individuals who had lost their individuality to "Big Brother." Hopefully, we can avoid these pitfalls while retaining a personal touch in our quest to select outstanding women and men into medical school. If we do not, we leave it to your imagination to determine what the outcome will be 10-20 years from now.

Julian J. Dwornik, Ph.D.
Deputy Dean for Admissions
USF College of Medicine

James A. Hallock, M.D.
Deputy Dean, USF College of Medicine
Assistant Director, USF Medical Center

WORTH REPEATING

Trip of a lifetime!

I wouldn't have done it for anyone but Casey.

Looking back now, I doubt if I'd do it again, even for Casey, lying in his bed of pain, or even for myself if I'd won 500 bucks from the Florida Medical Asssociation.

Which is a sort of mean thing to say, since they presumably will pay most of the bills. Nothing against FMA, you understand; just the amazed predictability with which I can complicate even the simplest things.

Let me try to reconstruct our trip last week to Buena Vista, which is the Gold Coast area bordering Disney World.

It began at home when my bride tripped on a rug while packing, fell flat on her kisser, hurting both knees. By the time we got there, she was hobbling.

BEFORE we got there, however, we had turned off I-4 one exit early, gotten literally lost in a huge parking lot and couldn't find the Palace Hotel — visible but unlocatable without the aid of a gas station attendant, a bus driver and an information house for wild-eyed tourists.

The Palace said we were supposed to be at the Royal Plaza. That was after I'd wandered the halls of the Palace, unwittingly two floors below the registration desk, found a lonely security guard, who said he wasn't quite certain where he was himself, and discovered a house phone which told me to go to the Plaza.

At the Plaza, which obviously was in cahoots with the Palace, all the computers said I was supposed to be at the Palace. A kindly desk clerk phoned a human at the Palace and the human agreed there'd been a mix-up and to send us back. The Palace manager cried all over me, got us registered and gave me tickets for two free drinks in the hotel night club, rather distrubingly called The Laughing Kookaburra. Instinctively, I knew we'd never go near it.

Then, I tried to check in at the Florida Medical Association desk and damn near became a delegate to an IBM convention because FMA wouldn't be there 'till next day.

We went to our room, my wife hobbling and baggage carried by a bellboy with a sprained ankle. It was quite a sight.

Thereafter, for an appreciable period, there was total collapse. I was, of course, baffled by the room "key" which is a card metallically treated, to be slipped into a slot. If there's a green light, you get in; if there's a red light, you consider suicide.

That evening, after dining at the "Watercress Cafe," which sounded like the cheapest food in the hotel and probably is, which is a meaningless statement unless you're accustomed to working with national budget figures, we staggered upstairs.

But not before we had seen a large, grassy park across a narrow inlet of Lake Buena Vista. Stunted trees dotted it. On one tree, and one only, were two electric fans, fixed to its branches.

Aware that nature offers no trees which bear electric fans, our hope to retain some rationality led us to learn that these were left over from an IBM

tent show the day before. So far as I know, they are still there.

I left the room carrying an ice bucket, in search of ice and vending machines. Fifteen minutes later, thoroughly lost, I happened across a hotel maid. She led me back to my room and showed me the vending cubby twenty feet from our door. It had a tiny, ultra-discreet sign "Vending" but, otherwise, looked like another hotel room door.

For the rest of the evening, my wife knitted and watched TV while I applied ice bags to her worse knee and smoked cigars on a tiny porch overlooking the lake, listening as a million frogs croaked in chorus. I could count, from my seat, seven other high-rise "motels" surrounding the lake. I feel certain the Disney people had those frogs on the payroll.

The Palace? Just your average small hostelry, with 952 employees. Its propaganda said proudly that it expected, in 1984, more than 800,000 guests to whom it would serve more than a million meals prepared by its 33 chefs — and who would have a choice of 99 different domestic and imported beers. There is a "99 Club," open only to the select few who've tried every brand of beer the Palace serves.

All in all, just a homey little spot catering to the weary traveler. If you're not weary when you get to Buena Vista, you are by the time you find the Palace.

Next day, FMA opened for business and I can report only that it is fortunate none of those doctors had to operate. I heard comments from several, however, who seemed quite eager to do a lobotomy on the architect who designed the hotel. One furious medic overshot almost to Daytona Beach.

I accepted Casey's 500 bucks for a statewide first among weekly newspapers handling medical journalism. He won for his series last summer on health care.

But if Gene wins another award next year, he'll just have to pick it up himself, whether they have to carry him in on a stretcher or wheel him in on an operating table.

I'm sure, next year, he'd meet some of this year's FMA delegates still trying to find the check-out desk.

Bill Needham
Port Charlotte

Reprinted with permission from the *Charlotte Sun*, May 9, 1984.

Battling for turf: the newest game in town

The battle lines have been drawn: More and more physicians are expanding the boundaries of their practices, asking for more privileges, and creating, in the process, internecine conflicts that have the potential of rending the unity of the medical profession. The situation can only get worse as the number of physicians continues to increase while the pie keeps shrinking.

This phenomenon in a way is a paradox, at a time of intense specialization and sub-specialization, when every branch of medicine has become a separate fiefdom, it is almost unthinkable to perceive that physicians will be crossing boundaries and doing things that exclusively were reserved, either by tradition or by unwritten rules of the game, to an established group of physicians. But the rules are changing fast and no territory previously staked by one group appears safe from the aggressive pursuit by other physicians. Radiologists are now doing needle biopsies and angioplasties; cardiologists are inserting permanent pacemakers; pulmonologists are doing bronchoscopies and pleuroscopies; and gastroenterologists are performing polypectomies and removing common duct stones.

To be sure, physicians who feel that their territories are being poached by newcomers have not taken the matter sitting down. The surgical specialists, in particular, have been appearing before hospital credentials committees more and more to be certain that privileges are not being doled out blindly. Their concern is probably legitimate: Many of the procedures now being done by non-surgical specialists are highly technical and have potential complictions that only surgeons are prepared to handle. It is hard to argue against this point particularly in non-academic settings where surgical specialists are not always available when needed. The issue,unfortunately, does not boil down simply to the argument of whether it is a surgeon or a non-surgeon who should be doing the procedures.

The technological advances in medicine over the past several years have afforded physicians the opportunities to expand their disciplines in ways not possible previously; one by-product of this development has been the blurring of boundaries among many disciplines and the sharing of a common core of knowledge among various sub-specialties. Endoscopy is an example of a procedure that has leveled the distinction between surgeons and non-surgeons. Once a procedure is perfected, this is passed on to residents and fellows in training, who in turn will expect to employ this expertise in their practices.

Many medical advances are not limited to purely technical procedures; the advent of CT scanning and ultrasonography, for example, has touched every medical discipline, with the result that more and more physicians are now staking their rights to a field that was once dominated by radiologists. The similar potential of NMR imaging is expected to attract a coterie of physicians from various specialties clamoring for a piece of the pie.

Behind the increasing push by many physicians for additional privileges is money. Make no mistake about that: Money is a big issue, perhaps the dominant issue. Procedural services, whether highly technical requiring years of intensive training or simple ones requiring a modicum of intelligence and a limited amount of training, fetch handsome financial rewards and will continue to be a magnet for a lot of physicians. The skewed reimbursement policies of insurance companies that continue to place a premium on procedures and technology will only perpetuate the problem.

The medical community of course has raised concerns about the possibility that physicians, impelled by financial motives, may be tempted to overdo procedures even for marginal indications. Another worry is whether physicians can maintain their efficiency in a setting where too many specialists are scrambling for a limited number of patients.

Beyond these concerns, the battle for turf may logically extend itself to the question of whether generalists like primary care physicians may be robbed of some of their traditional privileges because of the glut of specialists and super-specialists. It is already happening in many parts of the country. Many family practitioners and general internists are being squeezed out of their privileges to admit patients to intensive care units, and where they are allowed to do so, a mandatory consultation with an appropriate specialist is required. This development is probably fostered by the highly litigious atmosphere under which many physicians are practicing; in any event, the potential for turning physician against physician is there and can only hurt the medical profession and patients.

In a situation rife with conflicts, and where fraternal loyalty does not count, it behooves hospital credential committees to do the job of setting up strict guidelines, screening physicians rigidly, and monitoring their performance to ensure high standards of care and prevent abuses. It is a tough job but it must be done. The stakes are too high to make any mistakes.

R.G. Lacsamana, M.D.
Daytona Beach

Reprinted with permission from *The Stethoscope* of Volusia County Medical Society.

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussions of medical history and ethics; and articles dealing with socioeconomic, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to Daniel B. Nunn, M.D., Editor of *The Journal*, Florida Medical Association, Post Office Box 2411, Jacksonville, Florida 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal*.

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

Abstract. All scientific manuscripts should include a 150 word, maximum length, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double-spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the senior author will be sent an acknowledgement of receipt and a copyright agreement which must be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

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The Cancer Reference Book: Direct and Clear Answers to Everyone's Questions

By Paul M. Levitt, Elissa S. Guralnick with Dr. A. Robert Kagan, Dr. Harvey Gilbert. 287 Pages. Price $14.95. Facts on File, Inc., New York, 1983.

Cancer will affect the lives of most people either directly or indirectly. The authors feel that the facts about cancer have too often been either simply unavailable or confused and clouded by medical jargon. In this revised and updated edition, they have attempted to enlighten the layman about the known causes of cancer, which treatments are used to combat it, and how mortality rates differ among cancers. In an easy to use question and answer format, the authors convey the latest information on cancer in words that everybody can read and understand.

Why should patients and their families read this book? Because they often have questions that they are to timid to ask their physicians. Patients will use this book as a concise overview or as a reference source. Topics include what cancer is; its causes; how it begins and spreads; proven methods of treatment — surgery, radiotherapy, and chemotherapy; unproven methods of treatment, current cancer research, possible new treatments; prevention through dietary and environmental controls; and details of the twenty-one most common types of cancer and their characteristics.

"Widespread Cancer and Terminal Care" addresses the speical problems of the terminally ill. Patients are told the meaning of palliative treatment, they are advised against using unproven treatments in the hope that they might work, and they are told how terminal cancer alters a patient's view of the world. For the family and patient there is information on hospices, cancer insurance, pros and cons, grief and how death affects the survivors. In the chapter "Unproven Methods of Treatment", the authors tell of drugs, diets, and devices that have been advertised as cancer cures, but which have no proven efficacy. This subject is handled factually but without ridicule.

"Widespread Cancer and Terminal Care" reminds physicians that it is their responsibility to tell the patient that he is dying. The physician learns how the patient feels when he is denied the right to know that he is dying: "The patient, anxious to know if his time is running out, or if he should settle his family and business affairs, is left without an answer" . . . "the patient seeks confirmation about his condition from others; nurses, orderlies, social workers, family, friends" . . . out of frustration the patient finally grows angry and resentful or, even worse, silent".

The authors have included a glossary of important cancer terms and a partial list of comprehensive cancer centers throughout the world.

In conclusion I think the authors have accomplished their goal and the book is warmly recommended.

Jacqueline J. Jones, M.D., and
Ward D. Noyes, M.D.
Gainesville

• Dr. Jones is Senior Fellow in Hematology/Oncology, and Dr. Noyes is Professor of Medicine and Chief of the Division of Hematology, University of Florida College of Medicine, Gainesville.

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Auxiliary Liaison Editor — **Mrs. Walter (Isabella) Laude**

On the move and winning at the AMA-A Annual Meeting

"Change is the one certainty of our times." AMA-Auxiliary President, Glenda Bates reported that this has been a year of positive change: meeting the challenges of the 80s.

This convention marked the beginning of another Auxiliary year. Our Annual Meeting was a time to recognize the accomplishments of the past and the potential of the future. The newly installed President, Billie Brady, in her inaugural address, emphasized that "We must harness our vision of the future and move forward." She warned that our most dangerous foe is apathy.

Frank J. Jirka Jr., M.D., President of the AMA, stressed the importance of keeping the link between the Auxiliary and the Association very tight. The pressure that we are getting to hold health care costs down will not only persist but will increase.

The programs to reduce costs will be political in nature, therefore, the AMA and the Auxiliary must maintain a political presence. Dr. Jirka spoke of the AMA support of "MED VOTE," a project aimed at getting physicians registered to vote. Forty percent of our physicians are not registered! Physicians and their families must get involved.

William B. Deal, M.D., Councilor of the AMA Section on Medical Schools and Dean of the University of Florida College of Medicine, representing 127 medical schools, praised the Auxiliary for its fund-raising efforts. At the University of Florida College of Medicine, AMA-ERF funds have been used for emergency loans, to initiate faculty exchange programs, and to enhance medical programs in the humanities. The Delegates appreciated Dr. Deal's closing words, "The House of Medicine depends on you, needs you, and loves you."

Rufus K. Broadaway, M.D., President of AMA-ERF and a member of the AMA Board of Trustees, thanked the Auxiliary for the donation of $1,816,758.15 for financial assistance to medical students. Together the AMA and the Auxiliary have contributed over 40 million dollars in the 34 year history of the Education and Research Foundation.



FMA-A Delegates to the AMA-A Annual Convention lead by Mrs. S. Bruce (Priscilla) Gerber, 83-84 President, and Mrs. Laurin G. (Nancy) Smith, Chairman of the 21 Delegates.

The Florida delegation of 21 members applauded with pride as we received the first place award as the state auxiliary with the largest contribution to AMA-ERF in the amount of $117,651.67. We were also honored as the state with the second largest combined contribution of Auxiliary and Association for over $136,000. In addition, the Florida Auxiliary collected five membership awards: a first place for the greatest increase in AMA-A dues paying members (425); and a second place for new Resident Physician Medical Student Spouse members (333). Our three new counties, Bradford, Putnam and Hardee-Glades-DeSoto, were also recognized. We are the SECOND LARGEST STATE AUXILIARY in the nation.

The AMA-A is an organization of 80,000 volunteers: willing to take responsibility, to share, and to become more involved. We stand strong, unified, and ready to face the challenges of the future.

Priscilla (Mrs. S. Bruce) Gerber
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PRESIDENT'S PAGE

What are the real costs of the professional liability problem?



We are asking the citizens of Florida to support our Reason '84 Constitutional Amendment because we believe passage of this amendment will help reduce the surging costs of health care and will ensure the physicians' ability to deliver quality medical care to the people of Florida.

If the amendment is approved on November 6, we must be prepared to live up to this commitment. I am confident that we will do so.

Much has been said about the costs of the professional liability problem. In recent testimony before the House Ways and Means Subcommittee on Health, Congressman Richard Gephardt stated that we now spend about $35 billion a year on malpractice when all costs are considered.

A major portion of the cost is related to defensive medicine. Defensive medicine has been defined by the Commission on Medical Malpractice of the Secretary of HHS as "the alteration of modes of medical practice induced by the threat of liability for the principal purpose of forestalling the possibility of lawsuits by patients, as well as providing a good legal defense in the event such lawsuits are instituted."

Dr. James Davis, speaking for the AMA in a recent hearing before the Senate Labor and Human Resources Committee, stated that defensive medicine costs at least $15.1 billion a year. He indicated, however, that arriving at estimates of these costs involves subjective determinations that are difficult to quantify.

In spite of this evidence as to the costs of defensive medicine, a recently established "Committee for Responsible Health Care" under the sponsorship of the Florida Academy of Trial Lawyers issued a news release that contains the following statement:

> Defensive medicine is an emotional term. Its occurrence has never been verified or substantiated. No physician should order a test or procedure unless there is a medical basis for it. Without a medical basis, such a test would either be an assault and battery on your body or fraudulent medicine. Defensive medicine is actually one of two things: either a term to grudgingly refer to the more complete practice of medicine, or else a label to excuse the overutilization of our heatlh care system. Overutilization of health care has many complex causes, but the possibility of a malpractice claim is not a major factor. The truth is that unnecessary medical procedures produce unnecessary income to numerous parties, including physicians.

This statement is obviously inconsistent with the facts when one looks at a 30% to 40% increase in professional liability premiums each year and the rapidly escalating costs of health care.

There are costs other than monetary costs that are related to the professional liability problem. The American College of Obstetrics and Gynecology conducted a study in 1983 to determine the effects of the liability crisis on the practice of obstetrics and gynecology by its members. This study is one of the most scientific and complete of any studies conducted to date. Specific data was compiled for the ACOG members in Florida on changes in personal practice as a result of the risk of lawsuits. This data showed that 24.7% had decreased their acceptance of high risk obstetrical patients; 19.2% had reduced their number of deliveries; 17.8% had given up obstetrics altogether; and 11% had decreased the number of gynecological surgical procedures. Only 52.7% had made no change in their practice patterns. If this trend continues, there will obviously be a very serious

effect on the access to obstetrical care. This is understandable, however, when one considers that increases in liability insurance for obstetricians if they continue at the present rate of escalation may result in premiums in excess of a half million dollars annually by 1994.

Another serious non-monetary cost of the liability problem is the damage that has been done to the patient-physician relationship. Quality medical care depends upon open communication and trust between the patient and the doctor. Such communication and trust do not exist if the doctor is concerned about the patient being a potential litigant against him, or the patient looks at the doctor as an inviting target.

Another important non-monetary cost is that of negative defensive medicine. Negative defensive medicine occurs when a physician does not perform a procedure or conduct a test because of the physician's fear of a later malpractice suit even though the patient is likely to benefit from the test or procedure in question.

These costs, both monetary and non-monetary, are too high for the citizens of Florida to tolerate. We must, with their understanding and support, provide a satisfactory way of controlling them. That way is passage of our Constitutional Amendment on November 6. This will require a great deal of courage and a lot of hard work because success will not come easily. Some of the things that will be said about Florida doctors in the next few months will be hard to take.

"We must have courage to bet on our ideas, to take the calculated risk, and to act. Everyday living requires courage if life is to be effective and bring happiness."

Maxwell Maltz

Frank C. Coleman MD

Health of the public

Socrates noted that "one cannot get nearer to the gods than by giving health to his fellow man."

The theme of the 1984 FMA Annual Scientific meeting — Health of the Public — stimulated the FMA Committee on Public Health to contemplate the roles, influences and interactions of organized medicine and organized public health programming (government) on the current good health of the Florida public. It remembered that a Tampa physician, Dr. Wall, was largely responsible for the beginning in 1887 of organized public health programming in Florida (creation of the State Board of Health). It remembered that the State Board of Health played an important role in the early organizing efforts of the Florida Medical Association. It remembered that the highly successful attacks on yellow fever, cholera, typhoid, smallpox, hookworm, maternal mortality, diphtheria, polio, measles, crippling diseases of children, waste disposal, rats, safe water supplies and a whole lot more, all resulted from the collaborative, cooperative and combined efforts of the practicing physicians and government. Public health action in Florida has been always intrinsically related to organized medicine and the practicing physician. Public health programming and FMA attention to the health of the public are not separable.

It would be instructive and useful to the health of the public, the Committee thought, to cause a Special Issue of *The Journal* given to the public health aspects of the health of the public: a series of papers, by informed authors, reflecting on past patterns of common efforts into the "plagues" of yesteryear, identification and descriptions of contemporary "epidemics," and projections of possible solutions.

This Special Issue does that well. Though no real clear and encompassing answers emerge as to the current public health problems of health care financing, aging, genetic and developmental disabilities of children, pollution, AIDS, trauma, perinatal care of the poor nor the medically underserved, it is clear that answers lie in the continuing collaborative, cooperative and combined efforts of government and practicing physicians.

E. Charlton Prather, M.D.
Tallahassee

The right stuff

The best selling book *The Right Stuff* by Tom Wolfe and the movie based on it depict the frontier days of space exploration and the men who paved the way for our conquest of outer space. Now nearly 40 years later America has a greater appreciation of the risks taken by those early pilots, at least one of whom has become a hero complete with his own legend.

General Chuck Yeager, the first man to break the sound barrier, never made it to the glamour of the space program. Few hardly knew who he was until *The Right Stuff* swept America. His courage and determination in the face of extreme danger have become a legend long after that morning on October 14, 1947, when the first sonic boom was heard. The point is aptly made in the movie that America was built by men such as Chuck Yeager and that our

country will continue to grow and prosper through the efforts of future Americans breaking the sound barrier, as it were, in other fields.

Medicine has its own Chuck Yeager. To be sure, we have many great poineers of medical science, those whose discoveries have led to miracle cures and disease prevention. But the man who had the right stuff to stand up to the President, the federal beauracracy, and the public and tell them things they did not want to hear or believe is Dr. Ed Annis. Most of what I know about the early days of Medicare is anecdotal, but that is what makes legends. It took guts and conviction for Dr. Annis to speak out for the private practice of medicine 20 years ago and say things that have now come true. Today, he is the most effective public speaker I know who can cut right to the heart of complicated socio-medical issues. Just as he did in the pioneering days of the early 1960s, he has solutions to many of the problems facing society today. Some of us in medicine are listening; the government and the public, I'm afraid, are not. Like Chuck Yeager years ago, Ed Annis had the right stuff when it counted.

The private practice of medicine is under seige. A new Chuck Yeager/Ed Annis must emerge to set the record straight, ask tough questions and demand straight answers. It is time that medicine stop quaking in the corner like some freightened kitten and fight back when attacked. When we hear that it is a national scandal that 10.5% of the gross national product is spent on health care, why don't our leaders ask why this is scandalous. When physicians are blamed for the high cost of health care, why don't we point out loud and clear that we make up only 19% of total health care expendatures. If all doctors in this country were to cut their fees by 5% it would only save 1% of the total spent for health care or roughly 3 billion dollars. No one has pointed to the fact that all other non-MD health care providers also account for 19% of the total. I don't see anyone calling for dentists, chiropractors, podiatrists, etc. to freeze or cut their fees. When business berates us for their escalating health care costs, we should be telling them in no uncertain terms that unless they help us find a solution to the professional liability problem costs will continue to rise. Someone with the right stuff must stand up to business and demand that they tell the public what they plan to do with the money they will save if their health care costs decrease. Will they pass this savings on to consumers or simply increase their corporate profits? Will the dollars saved in health care costs be taken from the pockets of health care providers and placed in the wallets of corporate executives?

Ed Annis was not popular in the 1960s but he did what needed to be done at the time. We need a new Ed Annis to lead medicine to new heights in the face of adversity. But each of us can help in his own way. All physicians who care about their profession and the health of our patients must look for and find the right stuff hidden in all of us and tell the American public that our health care system is second to none and that we will fight to maintain it no matter what the costs. If we fail in our efforts we will be practicing horse and buggy medicine instead of medicine in the space age.

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Health of the Public



As guest editor of this special edition of *The Journal of the Florida Medical Association, Inc.*, it is a pleasure to bring you a stimulating provocative series of articles spanning the Health of the Public. These papers differ from classic scientific articles in that they often mix the history of their subject matter, the present Florida community application and future needs, goals and subsequent strategies. They mix classical health science, community health administration and occasional political science.

The Health of the "Florida" Public has a long history of steady improvement that in turn has improved the quality of life for both our citizens and our guests. We have come a long way from yellow fever, polio epidemics and bacteriologically contaminated drinking water. The diminished infant death rates and expanded years of life expectancy of Florida's citizens highlight our successes. The Florida Medical Association, physicians, and health professionals who have served Florida for the past hundred years can take pride in their contributions. In my tenure as State Health Officer and now as Deputy Secretary of the Florida Department of Health and Rehabilitative Services, the Florida Medical Association has consistently supported and lobbied for programs to maintain and improve the public's health. Two shining examples are emergency medical services and maternal and child health services.

We should not and cannot rest on past performances. Florida is a true megastate. Its rapid growth will increasingly stress our capability to maintain and improve upon our past successes both in human health and the maintenance of our environment. Major fiscal constraints and the large-scale evolution of alternative financial mechanisms will alter many of the "givens" we have taken for granted for the past decades. We are challenged to improve the efficiency and productivity of the health care system, but we musts vigorously guard against the disenfranchisement of large portions of our citizens or the lowering of quality of our services beyond what we would demand for our own families and loved ones.

Topics selected for discussion in this special issue range from a history of public health and county health departments to AIDS, from environmental issues to indigent care, from our enlarging senior citizen population to health care financing. Many additional subjects also could have been included. We do not have a paper addressing lifestyle and personal health habits. We know smoking, alcohol and failure to use seatbelts are costly societal problems. Drug abuse plagues too much of our population. Mental disease all too frequently plays havoc with our families and often leads to child abuse and neglect.

The Public Health Committee of the FMA and I sought to select topics we thought were timely and yet represented a kaleidoscope of Florida public health challenges. Our authors are to be commended for giving freely of their time and insight. On some issues you may vigorously disagree with the authors' views or perspectives. Be assured that each article is written sincerely and with the best of motivation. Where you take issue, reflection may be the best course.

I look forward to the challenges of Florida's future. I sincerely look to the Florida Medical Association and Florida physicians to continue and strengthen their commitment to the health of the public in these challenging, turbulent times. Creativity, innovation, commitment and integrity will be as essential as at any time in the history of Florida's medical profession.

James T. Howell, M.D.
Guest Editor
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Public health in Florida

A tradition of state and local partnership

Stephen H. King, M.D., John F. McGarry, M.D., Robert D. May, M.D., and Donald S. Kwalick, M.D.

Public health is rich in history and dramatic in its challenge for the future. This paper traces the more significant events, describes the evolution of current public health administration, and discusses where the future is apt to take us.

The past • Work takes on an additional value when the worker can look to the past and see that those in similar roles in previous times made a significant impact and that continuing traditional roles clearly hold the same promise.

Florida became a state in 1845 with 58,000 residents. Population centers were Tallahassee, Jacksonville, St. Augustine, Pensacola and Key West. The majority of the remainder of the state was uninhabited and remained that way until well into the 20th century. There was a growing fear of epidemic plagues and it was not unusual for local governments to exercise their authority with quarantines and epidemic containment activities such as wholesale incarceration and destruction of "infested" property.

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In the constitutional convention of 1885 a Board of Health was authorized and in 1889 it was established by the legislature. Yellow fever, smallpox, and cholera were major concerns with particular emphasis being directed to maritime activities in an effort to keep the diseases out of the state. An additional concern was the different and uncoordinated quarantine activities by local communities. It was thought that a statewide agency could help coordinate those efforts.

The original bill authorizing the state agency at first failed in the legislature because of the "exorbitant" cost — $200. However, a severe epidemic of yellow fever in Jacksonville during the summer of 1888 caused the governor to call the legislature into special session and public health in Florida was on its way.

For the next three decades there was rapid public and legislative acceptance of the need for cooperative attention to public health matters and the budget grew to $300,000 by the end of the first world war.

The post-World War I years and beginning of the Great Depression caused total resources for public health to be reduced by about ½ of previous levels. Attention was largely focused on environmental threats known to be predominant factors in epidemic outbreaks: insect vectors, water supply, sewage disposal, and protection of the food chain.

By the early 1930s through funds received from the federal government's new Children's Bureau and the Rockefeller Foundation, public health began a new era. Itinerant health teams from district offices provided immunizations and other preventive services to all segments of the population with a new idea — health education in personal health

practices. Technical assistance was provided along with major efforts for construction of wells, pit privies, municipal sewage disposal, central water supplies, mosquito control, and the purchase of shoes. Prenatal care and oversight of birthing developed into prominent features of programming. Required morbidity reporting and surveillance systems designed to reveal the causal factors of epidemics became more sophisticated. Recorded material from those times contain most of the ideas we are working so hard to develop into reality today.

The ability of the organization, however, to cover the entire state was becoming strained. Funds had become available through the federal Emergency Relief Administration Nursing Project, social security legislation, Works Progress Administration, and state legislature and a dozen programmatic administrative units had been established. The population was booming with almost 1.5 million persons. As a result the state directed its efforts toward establishing county health departments. Needed was a partnership.

The first county health department to be chartered was Taylor County in 1930. The fascinating saga of its beginning contain the makings of a tale similar to "Arrowsmith" and "Of Human Bondage." A large lumber company successfully removing virtually every one of the great old cedars was finding that its efficiency was being decreased by malaria, hookworm, and venereal diseases. The first public health nurse came under auspices of the lumber company. She was very successful, the illnesses decreased in incidence. She stayed to help the people with maternal and infant care and the emerging program of immunization.

The modern era began when the 1932 legislature provided authority for county governments and the state government to combine respective efforts for focusing on public health needs — the beginning of our 154 F.S. By the end of 1936 there were eight single county health departments, one bicounty department, and one four-county unit. By 1939, 16 counties were served by 15 full-time agencies. By 1945 there were 26 departments serving 37 of the 67 counties, covering 80% of the population. With the addition of St. John's County in 1960, all 67 counties were served by a local health department.

In 1939 the American Public Health Association was invited to send consultants to the state to study the program and suggest recommendations for improvements. Their report identified malaria and hookworm as health hazards needing attention and pointed out urgent needs for improvement in tuberculosis control, maternal and child health, and venereal disease control.

Beginning in 1945 more deliberate planning for change became necessary. Public health programming had become involved in many factors known to be involved in wellness — epidemic control, water control, food and its preparation and holding procedures, sewage disposal, atmospheric control, insect control and accident prevention. For two decades programs at both the state and county level matured and developed furthering the partnership begun by the legislature in 1931.

Under the constitution approved in 1967, the 1969 legislature reorganized the state government consolidating some 200 agencies into 23 departments. The old State Board of Health, as of July 1, 1969, became the Division of Health in the Department of Health and Rehabilitative Services. The operations and responsibilities of the county health departments were not changed.

Further action by the legislature in 1975 completed efforts at consolidation and modernization of state government. The organizational unit which fell heir to the rich mosaic of public health history is the Health Program Office and the director has the functional title of State Health Officer. The office has responsibility for program planning, policy development, program monitoring and assessment, establishment of standards and policies, staff development and training, technical assistance and other related activities essential to quality assurance in service delivery. Its responsibilities encompass all health programs operated by the department, including county health departments, and the review and coordination of all departmental health activities. In recent years this office has provided technical assistance and consultative advice to other state agencies as well. These activities command a preponderance of the State Health Officer's time — particularly in matters relating to the environment. The effects of reorganization has been that many of the traditional environmental health functions were moved into agencies other than public health, requiring significant interagency coordination.

Thus, there are now 70 chapters of the Florida Statutes which mandate that selected public health functions be performed by the Department of Health and Rehabilitative Services, along with several other chapters that assign traditional public health responsibilities to other agencies. The assigned functions include responsibility for milk supply, water supply, sewage disposal, shellfish sanitation, and occupational health. In essentially all cases, HRS is given primacy when a public health hazard becomes manifest.

The present • In 1983 the legislature significantly changed Chapter 154 (F.S.) for the first time since 1932. State government had changed a great deal in 50 years and modernization of the legal basis of the county public health activities was long overdue. Modern systems of accountability along with clarification of county and state expectations were in-

cluded in the amended act. There was continuation of voluntary funding by counties of cooperative efforts. Levels of service were described, and the director of the county program was placed in the more appropriate senior management class, being appointed by the Secretary of the Department after consultation with the State Health Officer and with the concurrence of the county commission. As all parties gain experience with this new legislation it is believed that new opportunities for funding, community support and program development are becoming available. State appropriation to the Public Health Trust has risen from $10 million in 1972 to over $50 million in the current fiscal year, not including new sources of funds from categorical state appropriation, federal funds and the rapidly expanding collection of fees.

It can be seen that the 50 years of partnership have resulted in a statewide system that for the most part enjoys significant continuing support from both partners. There is another partner which is not always recognized — being too often taken for granted. All physicians are taught the importance of public health to overall health. This state continues to have the support and assistance of organized medicine and is much the better for it. The advances in immunizations levels of children are an excellent case in point. We would not have been as successful if we had not had the unflagging support of the organized medical community. It is very important to remember that this is a three-way partnership with all three being critical to success.

The future • Again, the legislature has acted definitively by passing into law the Health Access Act of 1984. This landmark legislation clearly places Florida's public health community at the forefront of what has been brewing on the national horizon for several years. It establishes that public health is responsible for providing for primary care, a medical home for certain targeted populations. Over a period of a few years there is the clear expectation that a systematic program of care will evolve providing case management, home health care, and assured prenatal care for all the medically indigent in the state, with special attention to targeted populations such as the elderly, children, and the migrant agricultural farm worker. This care has been proven in a number of studies around the country as one of the few viable avenues to meaningful cost containment. The real opportunity is that Florida elected to be the first to actually implement such a program. We will all lead healthier lives because of it.

For those of us responsible for administration of these programs, perhaps there will be the biggest challenge yet to face public health. That challenge will be to carefully develop these programs and still look to the constantly emerging problems facing us from the past. We have not conquered the dangers of living in a hostile environment with its scourge of "plagues". Instead of malaria, it is contamination of our drinking water. Instead of smallpox, it is the terrifying enigma of AIDS. The more we learn of the pathogenesis of this disease the more potential for society-wide dissemination it seems to have. Instead of yellow fever, it is the sequelae of our lifestyles such as accidents, heart disease and lung cancer. Man continues to demonstrate an amazing ability to live beyond his means, to be able to constantly find ways to upset the ability of his environment to cope and adjust. The ability to reduce the mosquito as a pest led to the ability to develop our land with parking lots, condominiums, and the rampage of pests from intensive land use for agricultural advantage. Our health in the future ultimately depends on our ability to continue our partnership, to control the abandoned destruction of our environment and to provide a medical home for our citizens most in need.

Summary • For over 50 years county health departments have been an integral part of Florida's growing and challenging public health system. They symbolize a voluntary local and state partnership. Private physicians need to support public health, to utilize its services, and to participate in the resolution of community and public health problems. This state, local, and private partnership is the key to a successful future.

● Dr. King, Dept. of Health and Rehabilitative Services, 1317 Winewood Blvd., Tallahassee 32301.

A response

C.L. Brumback, M.D.

Response to an address which was to have been presented by Dr. Edward N. Brandt Jr., Assistant Secretary for Health, Department of Health and Human Services, was presented at the annual meeting of the Southern Health Association at Little Rock, Arkansas, June 15, 1984 by Dr. J. Michael McGinnis.

Most of my experience, beginning with internship in the Public Health Service over 40 years ago, has been in local public health practice. The view from the grass roots level is different from that at the mountain top, but I know that Dr. Brandt is a strong advocate of developing programs from the bottom up rather than the top down. So with that encouraging thought I will present some observations which occur from my perspective.

When I took my first course in bacteriology 50 years ago this spring, a relatively short time ago actually, the public health world was quite different. We were just beginning to apply knowledge derived from early research in bacteriology, biochemistry, physiology and pharmacology. Diseases like paralytic poliomyelitis and tuberculosis wreaked havoc. Similarly childhood diseases, influenza and other communicable diseases spread in waves through the population with an aftermath of premature death and disability. We had not yet begun to include chronic illness such as heart disease and cancer as legitimate targets for prevention. As a matter of fact, we did not speak much about preventive medicine and public health had a very limited connotation. Nevertheless, it seemed even then that we should be making much more effective use of available knowledge to prevent illness rather than almost the total effort in attempting to repair the later damage.

Major obstacles • Like others, I began with great enthusiasm, optimistic about the potential for improving the health of the public, but I soon realized that major obstacles lay in the way of achieving these goals. Most have been addressed in one way or another in Dr. Brandt's presentations and papers. To be specific:

1. The concept of prevention has been most difficult to sell because it is largely intangible. It is difficult to present or place a value on something that does not happen.
2. The medical and other health professionals have always been more interested in treatment than prevention.
3. More in the past than now, public health has been viewed as "socialized medicine" creating unwarranted difficulties in obtaining necessary support and cooperation.
4. Knowledge of public health on the part of professional disciplines as well as the general public has been lacking in proportion to the failure to emphasize this subject in education and training.
5. Groups of misinformed zealots have been able to effectively block legitimate public health efforts such as those concerned with fluoridation of public water supplies.

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6. Vested interests such as the tobacco industry have been able to exert undue political influence in hampering efforts to control harmful health practices, environmental pollution and other public health problems.
7. The successes in public health are largely based upon research; however, we have not given sufficient priority to research applicable to the field of prevention.
8. Out of the total expenditure for health care only a small fraction is specifically allocated to prevention.
9. Health personnel which continues to be in short supply are those needed for public health. We are simply not training enough to meet present or future needs.
10. During a large part of the past 20 years, official public health agencies have not enjoyed the support or close working relationship with the federal government as previously experienced.

Dr. Brandt is a strong advocate for public health and prevention. Repeatedly he has urged higher priority for these programs. In recent years this type advocacy has resulted in prevention being given greater prominence in national health policy. Dr. Brandt has emphasized the need for good epidemiologic data and its relationship to administrative and budget policies. He has pointed out the lack of substantial information on various population groups and health problems such as those related to aging, mental health, chronic disease, and environmental hazards. We are challenged to participate in efforts to obtain epidemiologic information in cooperation with agencies such as the Centers for Disease Control and to utilize this data in policy determination, priority setting and program development.

One of the concerns in my listing of problems refers to relationships between the federal government and the states or local communities. It has appeared to us at times during the past 20 years that state and local official public health agencies had been forgotten by the federal government. As health planning agencies and community health centers were established under tight control and guidelines originating in Washington, health departments, state and local, were almost ruled out of participation in a number of programs. The state of Florida had to give up its key role in the provision of migrant health services because there was no way for agencies to conform to some federal guidelines, personnel policies, for example. Although we may complain about reduction in federal funds, we should appreciate certain policy changes, and I quote from a statement by Dr. Brandt: "We are returning to the states and to the professions those activities that are properly theirs to control."

At this point I would like to register a plea for increasing communication between federal representatives and state and local public health officials leading to a discussion of problems and greater participation in policy formulation. Too many federal personnel have limited experience working with official public health agencies; however, there are encouraging developments which bring renewed hope for the future.

In regard to improving federal-local communications, in February Dr. Brandt met with representatives of the National Association of County Health Officials and the Department of Health and Human Services to discuss policy issues. Topics included program funding and the need for National Health Service Corps assignees in local health departments and better communications and technical assistance to local health departments. There are plans for these kinds of meetings to continue in order to expand the interaction between federal and county health officials.

Kind of help needed from federal government • Previously I mentioned a number of problems which must be dealt with more forcefully if we are to achieve our full potential in public health. I would like to express my view of the kind of help needed from the federal government and the response required from state and local communities.

We need higher priority for prevention in health programs and services. In 1980 we were challenged by the Department of Health and Human Services to work toward achievement of objectives in 15 areas of health promotion/disease prevention. Significant progress has already been accomplished; however, there is much more to be done. We need continuing leadership on the part of the federal government in refining and updating these objectives, monitoring progress toward meeting them and cooperating with state and local governments in program implementation. Although state and local resources must continue to be developed, they are limited and must be augmented by the federal government in appropriate amounts.

As Dr. Brandt has pointed out, more research effort must be devoted toward prevention. In addition to biomedical research we need much more knowledge regarding factors involved in human behavior. Although a great deal of this research must be accomplished at the federal level, Dr. Brandt has also pointed out the importance of contributions by local practitioners and administrators.

Prevention also needs to be emphasized in Medicaid, Medicare and private insurance plans. Until health care benefits are designed to emphasize preventive care and provide coverage for such measures, we will continue to be impeded in our efforts. Cooperative federal-state governmental

initiatives will be required to effect some of these changes and all will require cooperation of the private sector.

One of the greatest problems in meeting public health needs is a lack of trained personnel. We still have not achieved a great deal more emphasis on the teaching of preventive medicine, epidemiology, or public health practice, with some notable exceptions, than existed when I was in medical school. We need to increase this emphasis considerably, which will require federal, state and local cooperative efforts, with support of the private sector. An example of this deficit is the shortage of residency training programs for physicians in preventive medicine — public health and we have similar needs in regard to other disciplines.

The overriding emphasis should be on continuing and effective communication between public health officials at federal, state and local levels, and cooperative efforts in achieving public health goals and objectives.

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Florida's environmental health issues for the 80s and 90s

Stephen H. King, M.D., Victoria J. Tschinkel, and Thomas D. Atkeson, Ph.D.

A burgeoning population is the force behind the environmental problems facing the people of Florida. Between now and the end of the century, nearly 5 million new residents are expected to move to the state. The challenge is how to accommodate them without degrading the environmental systems which underlie the fundamentals of health and well being. This will require the best minds and an immense amount of work. Modern technology that has brought the contemporary high standard of living also has a dark side — threats of cancer and other diseases, toxic contamination of air and water, and severe stresses on the natural environment.

The interests and efforts of public health professionals and environmental scientists must converge toward the common goal of protecting Florida's citizens and the environment which supports them.

Government activity these next 16 years must be aimed at maintaining a balance. It will be necessary to determine where the risks of modern chemicals outweigh the benefits so it will be possible to protect Florida's ecosystem as well as public health from toxic exposure. To do this it will be necessary to enforce strict controls on where and how hazardous wastes are disposed of, protect natural systems which assist in detoxification of chemicals in the environment, and build an overall, integrated system of environmental management which includes public health and environmental professionals working in partnership.

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Chemicals and the environment: a balancing act • Modern technology has provided approximately 70,000 synthetic organic chemicals that appear to improve the quality of life in countless ways. But it has been found, especially in the last several years, that their benefits frequently come only at a price — more than 1,500 are acutely or chronically toxic, some even carcinogenic. Many are in everyday use and people are exposed to them in a variety of ways. Occupational exposure is frequently the most intense but more insidious is that impinging constantly on the general population through air, food and water. Therefore, it is necessary to walk a fine line, perform a sensitive balancing act, take advantage of the benefits of these chemicals and minimize the risks. The balancing act is complicated by the state's temperate to subtropical climate; porous, sandy soil; and high groundwater table. Because of the unique ecology, some chemicals which may be suitable in other areas are not safe for use here.

Current problems with toxic substances developed over many years, when no government agency had the resources or the direct responsibility to regulate these chemicals.

Troublesome chemicals are not only those with multiple-syllable, hyphenated names. Gasoline, diesel fuel, used motor oil, and cleaning solvents often contaminate drinking water and many of the

89 cases of known groundwater contamination are from these substances. They are much more widespread than those closely regulated by government agencies.

The present potential for contamination of groundwater is staggering. Florida has 600 landfills; 7,000 injection wells used for deep stratum disposal of chemical waste; 6,000 surface impoundments; 4 million septic tanks; 40,000 underground gas and diesel storage tanks, and almost 10,000 registered pesticides. There are 392 facilities or areas considered environmental or health threats. Of these, 29 are bad enough to be on the national priority list for Superfund cleanup funding, 14 are under enforcement action.

Recognizing the massive proportions of this problem, the legislature passed the Water Quality Assurance Act of 1983. Governor Bob Graham signed it into law on July 1 of that year. The $117 million Act has one overriding objective: to improve Florida's ability to deal with threats to the quality of its groundwater. This includes protecting public health from toxic substances and preventing chemical contamination of drinking water supplies. For the first time, there are programs and resources to help find the balance between risks and benefits of modern chemical technology.

Decision making should be based on the best available scientific research. The best answers, where there are close calls, will come from specific studies now being conducted on the various chemicals. Their aim will be to detect chemicals not suitable for release before they contaminate drinking water or other essential parts of the environment.

The new water quality legislation helps to build this foundation of objectivity into environmental decision-making. It also helps plug gaps in agency jurisdiction and remedies shortcomings in the regulatory process. The legislature has provided the tools to conduct objective and defensible environmental reviews. Science, not guesswork, can begin to arbitrate the sensitive point at which benefits outweigh risks.

New drinking water standards • Strict new standards for drinking water were adopted in April by the state Environmental Regulation Commission. The rule, part of Ch. 17-22, Florida Administrative Code, establishes "maximum contaminant levels" (MCLs) for eight organic chemicals in community drinking water systems. The MCL standards become effective June 1, 1985 for community water systems which serve 1,000 or more people and January 1, 1987 for systems serving less than 1,000 people. The chemicals to be tested for include vinyl chloride; carbon tetrachloride; trichloroethylene; tetrachloroethylene; 1,2-dichloroethane; 1,1,1-trichloroethane; benzene; and, notably, ethylene dibromide (EDB). The rule also mandates triennial sampling for 118 synthetic organic contaminants ("priority pollutants") in all community water systems. The sampling list includes most of the U.S. Environmental Protection Agency's "priority pollutants" as well as several pesticides which have been used in Florida and are suspected to be polluting the groundwater.

Another significant action is regulations for storage of polychlorinated biphenyls (PCBs). In addition to adopting the federal regulations, those agreed upon in Florida reflect greater sensitivity to contamination because of several more stringent provisions.

Under the 1983 water quality assurance law, a considerable commitment of resources was made to protect drinking water supplies during the 80s and 90s. These actions are concentrated on cleaning up hazardous waste, monitoring groundwater quality, assessing extent of the statewide hazardous waste problem, educating the public on need for proper hazardous waste disposal, and preventing contamination in the future. Highlights of the groundwater protection effort include:

Cleanup • In an effort to clean up existing contamination, it is anticipated that 36 hazardous waste cleanup projects will be initiated throughout the state over the next two years. High priority is also assigned to immediate response to environmental emergencies and sites which pose an immediate threat.

Groundwater monitoring • Florida is committed to a major program to assess the ambient quality of groundwater in the state especially in areas which have undergone heavy application of chemicals. This is a four-year program which includes drilling 1,600 new groundwater monitoring wells (400 per year) and analysis of samples from 1,500 existing wells.

Hazardous waste assessments • Another priority is continuation of local hazardous waste assessments in order to develop a credible statewide inventory.

Amnesty days • There is mounting evidence that the cumulative effect of many incidents of improper disposal of small amounts of hazardous waste is devastating. Each individual who disposes of a small amount of used oil in the back yard, each business which dumps small amounts of solvents in a septic tank, and each owner of a gasoline station who accepts used batteries must be made aware of the importance of proper disposal. For this reason, the Water Quality Assurance Act includes a three year "Amnesty Days" program for collection and disposal of small amounts of hazardous waste and for

education of the public regarding proper disposal of hazardous substances. The first "Amnesty Days" segment was this past May and June in southeast Florida and the Tampa Bay area.

Other programs • Other groundwater protection initiatives include the $100 million state sewage treatment construction grant program; improved septic tank regulation and increased emphasis on wastewater reuse. The pesticide review process is greatly improved and underground storage tanks will now be regulated.

Toxics and public health policy: the EDB challenge • The rapid advance in technology and in knowledge of basic pathogenesis of cancer and other chronic disease is a challenge to public policy-makers. Experience with ethylene dibromide (EDB) may provide insight to help illuminate this challenge.

It is known that there are carcinogenic chemicals in the environment, that there is no level of exposure below which carcinogenesis does not occur, and in general the majority of cancers are environmentally induced or modulated. Thus, in theory, public health regulatory policy should allow no amounts of any carcinogen to be placed in the environment. Practically speaking, however, this would be neither feasible nor necessarily desirable. This is so considering both the benefits of many of these chemicals and the certain negative economic impact of their loss. As previously mentioned, our society exists in a chemical world and even with optimum control many chemicals used will continue to test its homeostatic coping capacity and environment. The problems are complex and numerous.

There is very little epidemiologic evidence of specific carcinogenicity of environmental chemicals. Most studies are of occupational exposure. The scale, expense, and time necessary for good studies is immense. Risk assessment in man has almost all occurred by extrapolation. Very few of the chemicals that are carcinogenic in moderately high doses in laboratory animals (such as EDB) have been proven carcinogenic in lower doses in humans. Enough long-term, low-dose studies have been done in large populations of laboratory animals to conceptually support the extrapolation from high-chronic dose to low-chronic dose in animals. We must rely on this extrapolation for very little, if anything, can be done ethically to directly expose human populations on an experimental basis.

The fundamental transfer of known effects from laboratory animals to man has been substantiated in a number of ways. Much of the advance in treatment of malignant disease as well as search for its basic pathogenesis has been supported by this methodology. In addition, the study of chemical-induced mutation in bacterial and other cell cultures has been very useful in predicting toxicity in humans.

Florida has a unique opportunity to add to the sparse fund of knowledge by epidemiologic research on EDB-contaminated groundwater in households which can be identified, matched, and studied. This study will begin soon, including examining any correlation of congenital defects with EDB exposure in the past. It will be supported by the Department of Environmental Regulation, Department of Health and Rehabilitative Services, and Centers for Disease Control.

Once mathematical computations of carcinogenic events have been made, along with the "leap of faith" from animal data to the expected effects on the human population for a given chemical, how can one determine acceptable human risk? If it is true that for known carcinogens there is no level of exposure which does not cause cancers to develop, then how many cancers should one allow? Following an older process used in the development of vaccine preventable disease programs, the following methodology now is generally followed in risk assessment. If a cancer-causing agent present for the lifetime of 1,000,000 people would cause no more than one additional death from cancer, the risk is acceptable. If, however, the risk would generate greater than one death per 100,000 persons similarly exposed, the risk is unacceptable. The reason EDB was of such concern is that with the water and food levels which people in Florida had been exposed to, a lifetime of exposure could have been as high as one in 1,000, perhaps even higher for the very young.

Clearly, the problem has abated somewhat because the levels in food are lower and the time projection of exposure is now much shorter because of regulatory actions taken by the EPA. Still of some concern is the unresolved water exposure for about 50,000+ Floridians and the effects of even minimal exposure from food for the very young.

Though most agencies strive for levels that lead to risks of less than 1/100,000, this risk assessment policy does not completely resolve the issues which arise when one gets into risk management, the process which attempts to balance economic, political, and industrial interests with environmental public health interests. Frankly, this process, which is the one used by the EPA in suggesting levels of EDB for food, is difficult to quantify. It is important to understand the information which goes into such models and the weight given to various factors. For instance, it is obvious that all sources of exposure should be considered when a regulatory agency determines allowable levels in one part of the environment. Unfortunately, this was not done with EDB as food was considered to be the only source.

There are a number of lessons that have been learned from the experience with EDB. For instance, it was surprising how easily contamination could occur. The chemical had been used for many years with the assumption that it would not persist after its use. It was not demonstrated until approximately 1980 that residues in fumigated grain or in soil and water were persisting for extended periods. In addition, this ubiquitous chemical was not found to be carcinogenic until 1977. There have been many years of use in many places in our environment with the erroneous assumption that it was not harmful. Also, industrial dependence on the chemical was quite remarkable. Large segments of the agriculture, food, and petroleum industries used EDB. Although there was quick action to ban its use, this did not lead immediately to cessation of the problem. It has not been possible to quickly remove the chemical from human exposure. Some burden of risk from its presence will continue for an indeterminate period. Finally, the total cost for government and industry will prove to be quite high. The homeowner with a private well upon finding the water contaminated has to locate an alternative supply and the actual value of his property becomes questionable.

The National Research Council in a 1983 report entitled "Risk Assessment in the Federal Government: Managing the Process," concluded:

"The dominant analytical difficulty (potential carcinogens and similar hazards) is pervasive uncertainty. Risk assessment draws extensively on science, and a strong scientific basis has developed for linking exposure to chemicals to chronic health effects. However, data may be incomplete, and there is often great uncertainty in estimates of the types, probability and magnitude of health effects associated with a chemical agent, of the economic effects of a proposed regulatory action, and of the extent of current and possible future exposure . . . To make judgements amid such uncertainty, risk assessors must rely on a series of assumptions."

Whenever the regulatory agency has a choice whether or not to control something detrimental to the public's health, even if there are gaps in knowledge and uncertainties in fact, true public stewardship calls for protection of the public's health.

Health professionals and the environment • Though many physicians did not have the opportunity for more than a passing glance at the principles of public health while in medical school, they have heard of the triad of "the agent, the host and the environment." Physicians traditionally learn more about the first two than the third. This is unfortunate, since more evidence is available now than ever before that major disease and disability problems are to one degree or another caused, mediated or aggravated by environmental factors, particularly diet, smoking, and occupational or other exposures. Degenerative diseases do not have a single cause but instead result from many interplaying factors. The most enduring hypothesis about the origin of cancer is that a DNA alteration induced by the environment, predisposition, and the body's homeostatic capacity acting in concert result in an unregulated proliferation of cells.

Health professionals should always remember when counseling patients that a broad definition of the human's "environment" should include lifestyle factors like smoking, alcohol, diet and even sexual behavior. These are devastating, taking blame for 80% of cancers. Patients should know they are responsible for "risk management" also when it comes to controllable risk factors.

Our culture puts great stock in a number of "rights of passage," all of which appear to be symbolized by "cutting the cord." This is true literally at birth, symbolically at adolescence, and with some certainty at death. At birth our ties with and dependence on an intimate all-providing environment are exchanged for another through which we move with more freedom and more risk. Soon we have to assume a much more responsible societal attitude toward our environment. The leaders should be health professionals and environmental scientists in a partnership which benefits our state, its residents and visitors — present and future.

Working together, we can protect the health of Florida's residents and the unique and irreplaceable environment which supports them.

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Financing health care cost in Florida

D. L. Van Eldik, M.D. and Dirk W. R. Suringa, M.D.

Almost everyone would agree that the American health care system is the finest on earth and the envy of countries around the world. Physicians from other countries often continue their training at our hospitals, and patients from far and wide choose to be treated in our system which develops and boasts the latest state-of-the-art in technological and clinical advancements. This system of high technology and superior patient care has developed in an atmosphere of free enterprise in a fee-for-service climate.

Concerns about costs • The development of excellence, however, has been accompanied by an increasingly heated discussion over the last several years concerning the rapidly escalating costs associated with modern-day health care, especially as these costs compare to approximately two times the rate of increase of the Consumer Price Index (CPI) (Figs. 1,2). Politicians, health planners, employers, and to some extent the public at large have realized that the cost of health care is out of control and has reached an unacceptable level. Their feelings are best summarized in this quote:

> The cost of health care, the combined effects of price and utilization, is perceived as being out of control and unacceptable; thereby negatively affecting the delivery, access, and quality of health care. (FTFOCCHC)

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The question being asked with increasing urgency is: Are we getting sufficient returns in higher quality health care for the dollars we are spending, and are the cost increases being experienced each year commensurate with the return?

A question of perspective and priorities • Total health care expenditures should be placed in their proper perspective. The American people spend in excess of 10% of the nation's gross national product for health care, 17% on entertainment, and 8.5% on alcohol and tobacco.

While there is much debate as to whether 10% of the GNP for health care is enough or too much, a closer look at recent years' experience sheds some illumination on the present widespread concern over the cost of health care. Consider the following facts:

1. — Since 1976 hospital room rates have increased over 457% and have become the leading factor in the health care cost spiral.

2. — From 1979 to 1984 the Consumer Price Index (CPI) rose 44.3% while the National Hospital Input Price Index (NHIPI) rose 53.9%. In Florida hospitals gross revenues rose 118.7%, net operating revenues 94.9%, and total operating revenues 87.1%.

3. — In Florida, from 1979 to 1982, hospital expense per capita (age-adjusted) and total net revenues (age-adjusted) rose at an average annual rate of 16.3% and 16.9% respectively, exceeding the national average.

4. — As of 1973, Florida ranged 17th nationally in average hospital costs per capita when measured as a percentage of per capita income; by 1981 Florida had risen to 10th.

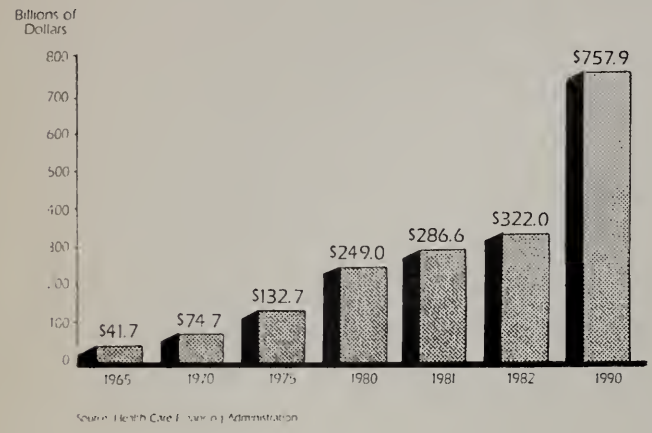


Fig. 1 — National Health Expenditures.

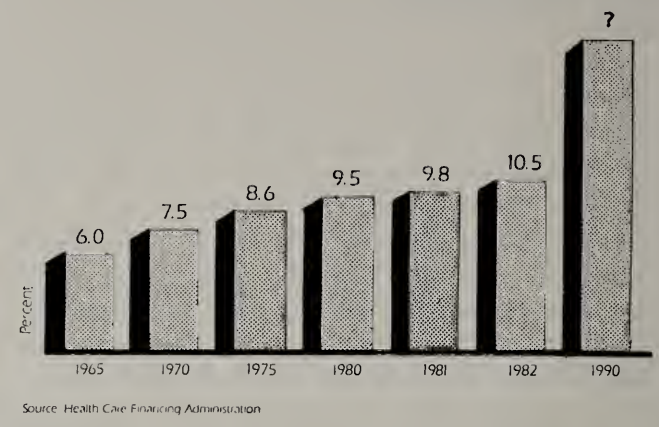


Fig. 2 — National Health Expenditures as a percent of Gross National Product (GNP).

5. — A 1983 survey of 235 Florida employers indicated that costs for employee medical benefits were $332.5 million in 1982 and $448.7 million in 1983, an increase of 35%.

6. — According to testimony by Blue Cross/Blue Shield of Florida, the average rate (premium) increase for health insurance in Florida was 39.8% in 1981 and 30% in 1982.

7. — A survey of Florida industries indicated that 44% had utilized cost-shifting approaches to contain health care costs and 38% anticipated future changes which would increase the employees' share of the costs.

8. — According to Joe Charles of Ryder Systems, Inc., "If the trend of the past several years continues, regarding the increases in medical benefit premiums and salaries, by the turn of the century, medical benefit costs will exceed salary costs for many businesses."

9. — For labor unions, the spiraling cost of health benefits has exacerbated a slowing in the growth of salaries and has resulted in higher out-of-pocket expenses for their members due to cost shifting practices by employers.

10. — When surveyed, a majority of Florida-based employers and the public felt that government should play a strong role in keeping health care costs under control, an anathema to most physicians.

While these facts are of utmost importance to health care economists, providers of health care are most concerned with the quality of care. In the overwhelming concern for health care costs, are we ignoring vital questions regarding accessibility and quality such as: Can we continue to pay the price of increasing and costly technology? Will advanced technology be made available to all citizens regardless of the ability to pay? Are we being forced into a double standard of health care?

Establishment of a task force • The broad-based multiyear upward spiral in health care costs was the impetus for legislation being enacted during the 1982 legislative session, establishing the Florida Task Force on Competition and Consumer Choices in Health Care.

The enabling act directed the Task Force to examine Florida's health care system and federal and private health care policies, and to develop and submit a report and recommendations to the governor and to the legislature which would lay out the actions necessary for Florida to develop and maintain a cost-efficient, quality health care delivery system. Specific attention was to be given to stimulating market price and service competition and to identify what actions would be necessary to assure meaningful access to health care and to cost-efficient care.

The initial charge was further elaborated during the 1983 legislative session by directive language requiring the Task Force to include in its report recommendations on a financing system for indigent care, the form and method for triggering a budget approval system tied to individual hospital and

industry-wide cost increases, and the form and method of a prospective reimbursement plan for Florida hospitals.

Competition vs regulation • The Task Force was established in a climate of debate between proponents of regulation and those who espoused price control through the dynamics of market forces. It was composed of 19 members representing a cross section of those interested in the health-care cost debate: politicians, businessmen, hospital administrators, labor and insurance representatives, nurses, senior citizens, and three physicians.

Frequently, the Task Force heard arguments either to "regulate" health care costs employing such strategies as rate setting or to "reform the market" to that traditional supply/demand economic behaviors would be activated to control prices. "Competition" or "market forces" refer specifically to pressures on providers and insurers to compete for patients or subscribers by setting attractive prices on their services and to bear the financial risks of their investment decisions. As purchasers of health care services negotiate, comparison shop, or request bids for hospital services, pressure is placed on providers to keep rates down to levels that supposedly attract patients.

The Task Force identified an intricate web of reasons for factors which drive the cost of health care upward. Some include the consumer's insensitivity to the real cost of health care (not paying any copayments); buffering effect of insurance on both providers and consumers; historical absence of price competition due to inflationary payment policies; competition among hospitals for doctors through improved technology; lack of adequate financing for indigent care and its resultant cost shift to other payers; tax policies which have previously engendered indifference to cost increases among employers (and employees) who collectively represent the second largest purchaser of health care after all levels of government.

Analyzing the factors, the Task Force developed a set of 42 recommendations. These represent actions which primarily will enhance market forces (the competition philosophy) and their inherent ability to control prices, a safety net to protect the public from hospitals whose prices are above reasonable levels of increase, and provisions for increased financing for health care services to the medically indigent.

Task force and physicians • While physician services account for only 28 cents of the health care dollar and have experienced a less dramatic rate of increase than some other sectors of the health care field, research indicates physicians do "trigger" as much as 70% of health care expenditures. This has led to increasing scrutiny of physicians and their practice patterns by hospital administrators, employers, public policymakers, and insurers.

Recognizing this impact on health care costs, the Task Force directed several of the recommendations toward physicians. Among these are suggestions that physician-education curricula include training in cost awareness; that relicensure be subject to continuing education requirements; that hospitals notify physicians of the charges for frequently prescribed treatment, procedures, and medications; and that physicians insure that patients in their offices are informed of treatment charges prior to rendering of care. Additionally, the Task Force recommended that the Florida Medical Foundation should examine physician patterns of practice and design continuing education programs to modify inefficient or excessively costly practices. The Task Force recommended that the Hospital Cost Containment Board collect and disseminate to the public physician charge information and generally encouraged the development and utilization of preferred provider arrangements and alternative delivery systems. The physician members of the Task Force repeatedly expressed their concern, however, that in the zeal for recommending alternative delivery systems at no time should quality medical care be compromised for an expedient though temporary cost benefit.

Ethical questions • Many ethical questions were discussed in the Task Force sessions as they related to cost of health care. These included the question of who would be eligible to receive the benefits of vast increased knowledge and technique. Should there indeed be a two-tiered system based on private or public ability to pay? Should there be an arbitrary age limit after which all advanced technological medical care would be denied? Should provisions of living wills be given more legal recognition?

The Task Force recommended that hospitals establish advisory committees to physician, patients, and their families in weighing and deciding when to utilize extraordinary medical treatment and recommended that the legislature enact provisions for "living wills" in Florida law. The Florida Supreme Court has upheld the right of the patient and family to carry out the provisions of a living will.

Harmful lifestyles related to health care costs • The Task Force became acutely aware that many of the most costly illnesses are directly related to harmful lifestyle habits but no specific recommendations were formulated. Nevertheless, those of us who practice in intensive care units know that the most costly care involves patients on respirators or requiring portal-caval shunts or those in cardiogenic shock — all of many more related to harmful lifestyles.

Medical malpractice and cost of health care • During Task Force deliberations, the issue of the cost of medical malpractice insurance and the behavior stimulated by the threat of suit (defensive medicine) were discussed on a number of occasions. Because of its complexity, the fact that a number of other groups were already concentrating on that issue alone and the Task Force had such a wide scope of subjects to cover, it did not examine the issue in detail nor try to formulate a specific recommended course of action.

However, during the discussion, the group did conclude that the malpractice problem has a negative impact on the cost of care in Florida. Both physicians and hospitals are reacting to the issue in ways that have had a profound impact on cost. The Task Force informed the legislature of its belief that if something is not done soon to address adequately the malpractice issue, it conceivably could frustrate gains that result from other recommendations.

The physician-members and hospital administrators on the Task Force identified what they believed were starting points for discussion and advanced them before the group. Although the Task Force did not endorse the specific provision of the recommendations, it voted strongly to urge the legislature to act this year on the issue and incorporated this position in the documentary section of the final report.

Results of Task Force's recommendations • The report and recommendations of the Task Force to the governor and legislature formed the core of recently enacted legislation entitled the "Health Care Consumer Protection and Awareness Act" and the "Public Medical Assistance Act."

This legislation has been hailed as a hallmark, representing a novel blending of market and regulatory strategies. Briefly summarized, it includes authorization for collection and public dissemination of hospital, physician, and insurance charges, establishment of a maximum allowable rate of increase for each hospital's revenues per admission, and authorizes the Hospital Cost Containment Board (HCCB) to sanction hospitals which repeatedly exceed the reasonable limits without good cause.

In addition, the legislation authorizes a significant expansion of the Medicaid program eligibility standards, thereby effecting increased federal funding to defray the cost of health care to the indigent in Florida.

Conclusion • It is very difficult to relate to politicians, health care planners, bureaucrats, and in some instances the businessman that a reward from the practice of medicine in the form of income is a consequence of practice and not its purpose.

The subject of health care delivery and cost is receiving considerable public attention and there are many misconceptions regarding the cause of the problem. However, the blame is often placed unjustly upon the physician because he is the most visible in the process of care of the sick. To blame the cost of health care on the physician is like blaming the engineer on a train for the cost of transportation. You can demand that the engineer get you from one point to another in a most expeditious and efficient manner but you cannot rightly blame him for the cost of the engine and fuel.

The Florida Task Force on Competition and Consumer Choices in Health Care was created to attempt to formulate recommendations which would alleviate the problem of escalating costs and most of the resulting recommendations if enacted would accomplish that result.

While neither the recommendations of the Task Force nor the resulting legislation this year contain provisions upon which everyone can agree, the consensus is that they represent solid and significant forward progress. Importantly, each effort enjoyed the participation and representation of the medical profession and it is critical that any future endeavors maintain the cooperative dialogue that began during Task Force meetings.

Members of the medical profession must unite to solve some of the current problems by taking positive steps which include more efficient utilization of services in and out of hospitals, explaining insurance programs for patients, moderating or freezing fees, and many of the other programs the Florida Medical Association has long advocated in its cost containment efforts.

We feel strongly that we should guard against development of a two-tiered system of health care delivery in which a discount medicine patient could become a second class citizen.

Balancing the issue of health care cost containment with our tradition of excellence in quality will continue to be the challenge for the medical profession as well as sincere public officials, business and industry. The collaborative cooperative efforts of many interests working toward the commom ground of understanding and resolution of conflict must form the foundation for the future of health care for the people of Florida.

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Indigent care — the growing dilemma in a competitive health care industry

Patricia Cowdery, M.D., F. Edwards Rushton, M.D., and Carl L. Brumback, M.D.

Health care of the poor is a problem which Florida shares with other states but it is more critical here because (1) the state's climate, location and other factors attract an influx of people from other states and foreign countries who are medically indigent; (2) there is great disparity in resources to care for this population; (3) the increasing cost of medical care has created serious fiscal, administrative and related problems for hospitals, physicians, public health agencies and other providers, and (4) malpractice suits have compounded the problem of providing medical care.

In consideration of differences in the extent and kinds of problems in the various parts of Florida, provision of medical care must take these into account. There are a number of ways physicians are working with others to develop programs for meeting medical needs. This article describes three such approaches. These programs will not work equally well in all places, however, each has certain features which may be adapted to particular situations. One feature is shared by all the programs: they were developed through cooperation of practicing physicians with others in their respective communities. Without such cooperation no health program will be successful.

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Indigent care in Jacksonville / Duval County • Every study of medical care for the indigent in Jacksonville/Duval County concludes that it is "fragmented." This is probably true anywhere in the country where there are multiple individual providers and provider systems, multiple payors, a large indigent population and no unifying broker or czar of health services to coordinate the pieces.

Jacksonville is a large urban center with a broader economic base and more stable population than tourist-oriented cities of the peninsula. It does not have a significant retirement or elderly community. About 16% of the population is below the poverty level and an additional 5% is slightly above. Medical care for this group of over 85,000 persons is provided largely by University Medical Center (formerly University Hospital of Jacksonville) with significant assistance by the Duval County Public Health Unit. Charity care by other hospitals, while helpful in individual cases, does not contribute much to the system as a whole while care in individual physicians' offices is unmeasured and its significance is unknown.

Given this broad picture, how does the system work and how is it paid for? University Medical Center is, of course, the hub of the care system and, for inpatient or complex care, is almost the entire system. It received approximately $18 million from the city in 1983-84 to care for patients not covered by Medicare, Medicaid or other insurance, and $1.6 million from the state for neonatal intensive care. It has also received federal funds for a three year pilot program to provide continuity of primary care for the indigent and medically indigent which has enrolled 15,000 patients and has approximately

30,000 visits per year. It is a major teaching institution linked with the University of Florida for outpatient services, has multiple specialty clinics, and an emergency room with over 100,000 visits annually. Outpatient visits total approximately 360,000 annually. All indigent care, however, is provided within its walls and this creates problems of access in a county of 840 square miles with little public transportation. Access is a problem especially for those requiring continuing outpatient care and living far from the hospital. Hospitalized patients come from the entire county (and other counties) but outpatients reside mainly in nearby census tracts.

Providing some modicum of primary care in the remainder of the county for those who cannot pay is a role recently assumed by the county public health unit. This department has always had traditional public health outreach services throughout the county — well baby and immunization, family planning, maternity (for delivery at University Medical Center) — but in 1977 took over and has expanded somewhat the limited walk-in services once provided by the local OEO agency. Care is provided by teams consisting of MDs, PAs, and ARNPs. These roving teams are seeing approximately 20,000 patients annually with services ranging from cardiovascular screening and preschool physicals to general medical care. University Medical Center is the backup for x-ray and hospitalization and for complex laboratory work in spite of the fact that the health department and hospital lack a shared record system except for maternity patients. This lack creates an almost impossible situation in patient management if both providers are involved.

There are no "earmarked" health department dollars to provide this nontraditional care and the shrinking budget phenomenon puts it in jeopardy for the future. Services provided by the health department have not been built into the planning stages of any of the new delivery systems of HMO and HMO variants. Medicaid has no "alternative delivery system" in the wings for the health department to join with the University Medical Center pilot program which is scheduled to end this year.

Not only the health department but University Medical Center also project a shortfall with, among other things, loss of the Medicaid pilot program, the 14% increase in indigent patient load over the past year, and the small proportion of private patients who use the hospital.

Another thorny question arises when comparing hospital usage by indigent and nonindigent in the area. Even though many studies show that the indigent have poorer health and more days of restricted activity than the nonindigent, a study by the Northeast Florida Health Planning Council found that under age 65 the indigent received 23% less days of hospital care than the general population (627 days per 1,000 vs. 815 days). Only in obstetrics and psychiatric services were their usage rates higher than paying patients. If a further cutback of usage in medicine, orthopedics, surgery, GYN, cardiology, urology and proctology is necessary to meet budgetary constraints, questions can be asked if this is efficiency and laudable cost containment at work or does the city have a double standard of care?

Like those elderly and retired living on fixed incomes and seeing the quality of life erode, providers of health care to the poor find their resources becoming thinner and thinner. The "unbundling" and spin-off of profitable components of care is not a luxury possessed by those providing indigent health care . . . all their components are unprofitable.

Program for primary child health care in Sarasota County • A survey of the Migrant Health Clinic for children in Fruitville in 1969 showed to our surprise that most of the children were not migrants at all but yearly residents of downtown Sarasota. Subsequently a volunteer clinic one night a week was sponsored by St. Martha's Church for these children. During the first year more than 500 visits were registered, a graphic display that a more permanent and complete home was needed.

The successful expansion of Children's Medical Services statewide stimulated local interest in developing such a primary health care project. Since Children's Medical Services had shown that public administration and money working with proven private practice excellence could provide good care at a lower cost to children across the state with chronic rehabilitative problems, then such a system might work well locally for primary care.

The director of the Sarasota County Health Department at that time was an enthusiastic supporter of such a program. With his help, an organization was developed to provide primary health care for indigent children 24 hours a day, seven days a week, year around. A pediatrician in private practice was appointed director of child health care in the Sarasota County Health Department. Parenthetically, it is noted that initially the pediatrician who was medical director of Children's Medical Services was also director for primary care in the health department. Later a separate appointment was made.

The responsibilities of the director of Child Health Services are: (1) to arrange with other pediatricians in private practice to staff the clinics; (2) to provide supervision for the nurses, clerks and registrars working in the clinics and instruction opportunities for them; (3) to serve as a bridge between the Child Health Program and other family practitioners and specialists working in Sarasota County, and (4) to coordinate the Primary Health Care Program of the health department with other state-

sponsored programs including Children's Medical Services, Children, Youth and Families, Developmental Services, and School Health.

Provision of primary care for indigent children by Child Health Services is supported by nearly all pediatricians in private practice. A group of six in one call system agreed to staff the clinic five mornings a week. Sick children arriving after the physician leaves are screened by a public health nurse assigned to this service. This nurse evaluates well-delineated problems and provides treatment following a preestablished protocol. If there is any uncertainty, she contacts the pediatrician on call for direction and support. When the child requires a visit, he is referred to the pediatrician's office and treated there.

Out-of-clinic services, such as evening and weekend calls, are provided with the use of an answering service for the clinic telephone. The pediatrician responds to these calls and to calls for emergency room treatment and hospital admissions as he would with private patients. If hospitalized, the patient is followed in conjunction with the public health nurse and discharge instructions are given both to her and to the parents. Follow-up visits are scheduled in the clinic.

An annual contract fee is established for the physician component of the program. The Child Health Director distributes the funds to the participating pediatrician on an agreed upon formula, which also covers services rendered by the pediatricians to patients of Child Health Services for the year. It was discovered that the program reduced emergency room visits and hospital admissions, which more than saved the amount of monies spent for the professional component of the program. The health department and county continue to supply the salaries for the nurses and clerks and funds for the physical facilities of the program.

We discovered a close arrangement could be erected between primary child health care in the health department and the chronic rehabiliative care of Children's Medical Services. If a patient is found to have a chronic, rehabilitative problem either through primary care or EPSDT screening, the initial examination is done in situ and translated to Children's Medical Services. The patient is then referred to subspecialty care with a complete PE already annotated. Close follow-up is established in both units so that identification and tracking through this system is enhanced and duplication of services avoided.

Following this example, a different group of pediatricians arranged a contract with the health department and county to provide care for newborns of indigent mothers. Newborns are followed by a public health nurse and upon discharge are referred to the health department well baby clinics staffed by pediatricians in Child Health Services.

The final component of our system was established when Children's Medical Services created a step-down nursery in Sarasota Memorial Hospital. Patients referred to tertiary neonatal intensive care can be brought back to Sarasota for less expensive level "2½" care. Upon discharge from the step-down nursery a conference is held between the director and the appropriate health care system.

It is hoped that by intermingling of the four components of the program that fewer children are lost "through the cracks" to our health care. Although adjustments in clinic attendance by professionals and participating individuals have occurred over the years, the system remains viable, growing and effective. The success of Sarasota's program still relies on the spirit of cooperation between public administration and monies and those with proven private practice excellence who are qualified to carry out the professional component. There is no doubt that monies spent early on, "up front", in preventative and good health care for children save a great deal more "out back" as they reach young adulthood.

Indigent care in Palm Beach County • Palm Beach County has experienced most of the health problems of the remainder of Florida in addition to some which are relatively unique. Although the name may evoke an image of wealth, actually a major portion of the population have incomes below the poverty level. The poor live in rural as well as urban areas and include various minority groups, seasonal farm workers, and refugees. They seldom have health insurance and Medicaid covers only a fraction of the total cost of required medical care.

There is no public hospital in the county and until fairly recent years a majority of indigent patients needing medical care have gone to emergency rooms of private hospitals or physicians' offices often with critical conditions requiring prolonged hospitalization. Thirty years ago there was no organized system of care and most of it had to be provided by the private sector.

The county health department initially became involved in the provision of primary care with agricultural migrants and seasonal farm workers. This population had many health problems and resources for care were frequently minimal in areas where they lived and worked. Fluctuation in numbers resulted in seasonal overloading of these resources and migration complicated diagnostic and treatment procedures. Health problems were further compounded by a combination of social, educational and cultural factors.

The Palm Beach County Medical Society and local hospital representatives met with health department personnel to discuss these problems. Following a series of meetings, the health department was requested to initiate a project to provide

basic health services. Assistance of the State Board of Health was sought and a special grant was obtained from the U.S. Children's Bureau to initiate a health program in western Palm Beach County. A plan was developed in cooperation with the county medical society which emphasized a team approach for meeting the complex problems of the population to be served. The team was comprised of a pediatrician, family practitioner, public health nurses, nutritionist, health educator, social worker, sanitarian, and a young nurse's aide who came from a migrant family. The nurse's aide served as an interpreter and liaison between the professionals and the farm workers.

It was not easy to provide health care to people who were not accustomed to seek medical attention until the problem became an emergency. Maternity care was given by lay "granny" midwives, infant mortality was very high, communicable diseases such as tuberculosis and those due to poor sanitation were rampant, and chronic illness was neglected. Members of the Migrant Health Project staff persevered over a number of years, beginning in 1956, in efforts to educate the people, identify medical problems, provide early diagnosis and treatment, and to emphasize preventive measures such as immunization and sanitation. A plan was developed with local hospitals and physicians to provide prenatal care and hospital delivery. A mobile clinic provided services in farm labor camps. Health education was carried out in a variety of ways: through classes held in conjunction with clinics, pamphlets and visual aids using language and terminology which could be understood, and special patient education. Sanitation in labor camps was significantly improved.

The result of this program was progressive improvement in the health of farm workers as shown by reduced infant mortality, marked reduction in the incidence of communicable disease, decrease in the number of crises due to neglected problems, and less time lost from work due to illness. Hospitals, physicians, farmers and people in the communities welcomed these changes.

As an outgrowth of the migrant health program, the Board of County Commissioners requested the health department to organize a countywide program for medical care of the poor. Again, meetings were held with county medical society representatives, hospital administrators and other concerned individuals to determine the feasibility of such a program. There was agreement that the health department should develop clinics in various parts of the county which would provide general medical care in addition to the usual public health services such as tuberculosis, venereal disease control, and immunization. Medical staffing would be provided in large part by private physicians. Private physicians also agreed to accept referrals for certain specialty care and to provide inpatient care. Agreements were negotiated with hospitals and emergency room staffs. The Florida Relative Value Scale, specialty contracts, hospital per diem rates, and other methods of reimbursement were developed and these have been renegotiated over the years.

Success of a program such as this depends upon cooperation of the medical profession, hospitals, laboratories, and public health agencies. The program itself requires the cooperative effort of a multidisciplinary team. The result can be a cost-effective way to provide quality medical care and public health services to a population with many complex problems.

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Child health care: prevention and early intervention a must

Robert K. Wilson Jr., M.D., W. Reed Bell, M.D., and Richard J. Boothby, M.D.

The title is axiomatic. "How true!" one might exclaim. "Everyone knows that!" Where does it all begin and is there, in fact, truth embodied in the statement "Child Health Care — Prevention and Early Intervention a Must?"

Each author began careers in pediatric practice settings and now views child health care from different vantage points. School Physician is a relatively new concept. One of us (RJB) is privileged to fill such a position for a large public school district in northwest Florida. Since 1969, after 12 years of practice, one of us (WRB) is director of a hospital based, community-oriented pediatric training program in northwest Florida. Finally, one of us (RKW Jr) is presently the "County Doctor" (County Public Health Unit Medical Director) for a moderately large county (250,000 people) in northwest Florida after a ten year stint in private practice followed by three years in academia in the teaching program previously mentioned.

Child health care extends from the cradle to college and responsibility for providing comprehensive care during this time is shared by parents, physicians, and school people. Among the numerous health care professionals who care for children, the pediatrician, family practitioner, and public health physician usually are the first responders to the health care needs of the infant, toddler, school age child, and teenager.

As we were pooling our collective wits about this rather comprehensive subject we determined that it might be considered by some to be less than interesting; to be perfectly candid — boring. Why is that? We have been involved so long with all of this that much of the mystique has dulled a bit with time.

Reflecting on it stirrred in us a fresh new way of looking at screening, at intervention and finally at the results of the labors of countless practitioners, researchers, public health officials, and paraprofessional personnel.

The prototype of "prevention and early intervention" is screening for congenital hypothyroidism.[1-3] Practitioners for years have seen patients with various problems such as mental retardation, seizures, cerebral palsy, blindness, deafness, and autism. The notion that specific, sensitive tests would be available, reasonably inexpensive (and cost effective), for the diagnosis of diseases that could be treated very early and thereby prevent the morbidity described above was mind boggling. Our prototype disease — hypothyroidism — which is found in 1:3,000 to 1:4,000 live births does occur sufficiently often to realize rather quickly the impact of early intervention. Except for the need for daily replacement of thyroid, afflicted children lead normal lives and attain the intelligence they were genetically endowed assuming early detection and immediate therapy. And so it is with a whole host of metabolic diseases that engender much morbidity and even mortality if not recognized — reasonably startling fact and certainly not boring.

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Almost ten years ago a symposium related to screening in child health care appeared in one of the major pediatric journals.[4] The major issues regarding screening are addressed as well as a listing coupled with explanatory comments of many, if not most, of the conditions that lend themselves to screening. PKU was one of the first diseases screened in the newborn period and also one of the first where states passed laws requiring testing be done.[5] Screening for urinary tract infections remains controversial,[6] nonetheless most would argue for its value especially in young girls. Lead screening[7] is of value in some geographic areas but not all, even in the state of Florida. Tuberculin skin testing[8] is unquestionably of value nationwide.

Many of us become almost overly enthusiastic about screening and what we feel it can do for us and the public at large. We have to be made to face the cold, hard reality along the lines most persuasively articulated in an article[9] appearing a decade ago which is as truthful now as it was when it was written:

"Screening and screening programs to date have largely failed to fulfill the hope that early detection will lead to more effective early treatment and to improved health status in the populations served. Part of this failure is due to inadequate knowledge and technology, but much can be attributed to programs which have failed to incorporate very basic principles described in the following paragraphs.

1. Screening must be part of a program that ensures effective treatment for problems discovered.
2. Tests used and problems sought must have certain specific characteristics to be suitable for incorporation in screening programs.
3. The dangers of mislabeling through screening must be avoided.

If future efforts are to be more successful than those in the past, they will have to learn from and correct the mistakes of the past. The following lessons seem to be among the most important:

1. Screening is not and cannot be a substitute for other elements of health care. Primary prevention, care of episodic symptomatic illness, management of chronic illness and handicaps, and health counseling and education can sometimes be potentiated by, but never replaced by screening. Screening is one means of alerting people that they may need medical care, it is not a system for the delivery of medical care.
2. The existence of a relatively simple test does not automatically justify its routine use in screening.
3. Screening provided in the setting of comprehensive health supervision is much more likely to lead to effective intervention than is screening provided in other contexts.
4. The cost of screening is greatly reduced when a single administrative system is used to carry out testing and follow-up for a number of problems. Regionalization of specialized laboratory, administrative and diagnostic services can improve effectiveness and economy.
5. All screening — whether in health supervision or in special programs — must be evaluated periodically to be sure that it is having its intended results: improved health status through identification and treatment of remediable problems."

There needs to exist a continuing effort to bring together the public and private sectors of medicine so that the resources of one sector may be utilized by the other thereby saving time, money, and in the end providing a more comprehensive child health package to the public.

The two of us who reside at the "Western Gate to the Sunshine State" feel privileged to collaborate on this project with one who is a school physician — an exciting and fast-becoming-much-needed member of an innovative county public school program. He submitted the following outline which depicts quite nicely what areas are addressed at various ages and stages:

Outline

Early Intervention Programs
- Child Find (Ages 3, 4, 5)
- Follow Through (Ages 5, 6, 7, 8)
- PREP (Ages 5, 6, 7, 8)

Screening Programs for Detection of Specific Health Problems
- Vision
- Hearing
- Scoliosis

Prevention and Treatment Programs
- Immunization Program (Grades K thru 12)
- Dental Program (Third Grade)
- Health Counseling Program (Junior High School)
- Health Counseling Program (Senior High School)
- Sports Medicine Program (Grades 9, 10, 11, 12)[10]
- Alcohol and Drug Abuse Programs (Elementary, Junior, Senior High School)[11]
- Project Impact
- Substance Abuse Evaluation Process

Additionally our Northeasterner defined "Child Find" as it exists in his area. Escambia County has a similar program.

Child Find • One of the first challenges a school district encounters when it elects to serve preschool children is to locate and identify those who are eligible and would benefit from a screening program. Child Find provides services to a three-county area in northeast Florida. It represents one of the first activities in providing a total early educational intervention system. The program is designed to sort out from an apparently well population those children who are at risk of having the condition screened for and are, therefore, in need of additional evaluation. The screening procedures help identify children and are designed to be fast, efficient techniques for determining which ones may need special early intervention in order to successfully compete in a school environment. These children usually manifest only mild or moderate handicapping conditions but without early intervention they may experience repeated failures. Child Find conducts open screenings throughout the tricounty areas.

A Preschool Prescreening Checklist is utilized to encourage parents and Day Care Center directors to have children screened.

Children go through a series of activities in the vision, speech and language, hearing and developmental areas.

Those children identified as possibly having handicapping problems are referred to existing public school programs or if no school program exists the parent and child are directed to the proper community agency.

Follow Through Program • The Follow Through Program is conducted in all Duval County public schools and one of its primary objectives is to identify students who have medical and/or dental problems that are hampering classroom success and refer them to appropriate agencies. Annually during one week in January, special emphasis is placed on observing the medical and dental needs of the children in the Program. Teachers are provided with a guide for health observations prepared by the school physician which enables them to more readily identify students who may need health referrals.

A scholarly approach to pediatric screening is presented by W.K. Frankenburg.[12] It is worthy of review. One of the senior residents in our local pediatric program asked me (RKW Jr), "Do you really want to read an outstanding series of articles on screening and share the discovery with others?" Naturally he received an affirmative response. The series is entitled collectively "Pediatric Screening Procedures."[13] It has all the hallmarks of a "classic" save standing the test of time; no doubt, in a few years the classical label will be most appropriate.

The probing minds and insightfulness of house officers have positive effects upon preceptors and professors as they are made to stay a step ahead if possible; thereby discovery and earlier intervention is a frequent consequence.

The following is a list, by no means exhaustive, of diseases or conditions that lend themselves to screening, early intervention, and in some cases prevention: Phenylketonuria, Galactosemia, Hypothyroidism, Maple Syrup Urine Disease, Other inborn errors of metabolism, Anemia, Sickle cell diseases, Hemoglobin S and C traits, Bacteriuria, Impaired hearing, Impaired vision, Deviant physical growth, Deviant psychomotor development, Glucosuria, Albuminuria, Cystic fibrosis, High blood pressure, Hypercholesterolemia, Deviant behavior, Intestinal parasites, Dental diseases, Lead absorption, Tuberculosis, and Occult stool blood.

There is an additional area we would like to alert the reader to keep in mind as a lowered sensitivity may result in a fatality. The area of concern is depression in the adolescent.[14] Its presentation often is subtle or unrecognized for what it is. Whether the health care provider can truly prevent depression is uncertain. Once recognized, however, intervention is of prime importance as failure to act may result in a suicide — the third leading cause of death in the 15 to 24-year-old age group.

In child health care is prevention and early intervention a must? We think it is. In point of truth our corporate experience allows us to go a step further. We know it.

References

1. Fisher, D. A.: Screening for Congenital Hypothyroidism, Hospital Practice, December 1977, pp. 73-78.
2. Levy, H. L.: Regional Newborn Screening for Hypothyroidism, Pediatrics 63: 340-341, 1979.
3. Fisher, D. A., et. al.: Screening for Congenital Hypothyroidism: Results of Screening One Million North American Infants, J. Pediat. 94:700-705, 1979.
4. Symposium on Pediatric Screening, Pediatrics 54:608-640, 1974.
5. Scriver, C. R.: PKU and Beyond: When Do Costs Exceed Benefits? Pediatrics 54:616-618, 1974.
6. Kunin, C. M.: Current Status of Screening Children for Urinary Tract Infections, Pediatrics 54:619-621, 1974.
7. Moriarty, R. W.: Screening to Prevent Lead Poisoning, Pediatrics 54: 626-628, 1974.
8. Edwards, P. Q.: Tuberculin Testing of Children, Pediatrics 54:628-630, 1974.
9. North, A. F. Jr.: Screening in Child Health Care: Where Are We Now and Where Are We Going? Pediatrics 54:631-639, 1974.
10. Goldberg, B. and Boiardo, R.: Profiling Children for Sports Participation, Clin. Sports Medicine 3:153-169, 1984.
11. Committee on Adolescence 1982-1983, Long, W. A., Chairman: Role of Pediatrician in Substance Abuse Counseling, Pediatrics 72:251-252, 1983.
12. Frankenburg, W. K.: Pediatric Screening, Advances in Pediat. 20:149-175, 1973.
13. Diaz, C., et. al.: Pediatric Screening Procedures, Advances in Pediat. 29:409-470, 1982.
14. McAnarney, E. R.: Suicidal Behavior of Children and Youth, Pediat. Clinics N.A.: 22:595-604, 1975.

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Maternal and child health: developing a strategy for the medically indigent in Florida

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More than a decade ago health care professionals in Florida confronted the first grim fact that infant mortality rates were among the worst in the United States. Moreover they found that the state had one of the highest perinatal mortality rates and that tens of thousands of children and pregnant women failed to receive adequate medical care. In the intervening years the state has taken dramatic steps to reduce the statistics and to provide adequate medical care for this population.

In 1974 Children's Medical Services was created and remains a premier program for the care of sick children. In 1981 small funding amounts were set aside for the first Improved Pregnancy Outcome programs; these have flourished and are beginning to provide early prenatal care for women who formerly would not have received such care. These programs include the federally-funded food supplement programs for women and children (WIC), children and youth projects and provide care for a large segment of the "truly needy" population in Florida. Now in addition, five-year plans have been designed by the state Department of Health and Rehabilitative Services to insure care for all mothers and children currently not being served even though this population falls into the indigent category.

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However, another large category of mothers and children exists which is commonly labeled "medically indigent". Broadly speaking, this term refers to those not poor enough to qualify for existing programs who are, nevertheless, too poor to buy care on the open market in the private system of health care.

Present poverty guidelines indicate a $9,000 cutoff point in annual income for a family of four. Thus, 150% of poverty would indicate an annual income of $13,500 for this same family; consequently, many single-earner families in the state, many state employees (teachers, secretaries, nurses) qualify as "medically indigent".

The recent recession with resulting high unemployment rates in parts of the state such as Bay and Polk Counties has swollen the ranks of the medically indigent, bringing their case to the forefront in both public health and private medicine in a way more forceful than ever before. Certainly, the unemployed who have lost benefits previously enjoyed tend to be a more vocal consumer group than the traditionally deprived whose economic status have never permitted them participation in the open market for medical care. Also, these recently unemployed who have lost benefits know by experience what they can reasonably expect in terms of adequate medical care and they, therefore, can more readily demand such care.

The unavailability of health programs for the medically indigent may force mothers and children to become truly indigent as they try to maintain previously known standards of health through pursuit of adequate health care for which they must be financially responsible. What follows are our thoughts on how the medically indigent may receive adequate medical care without being added to that traditional class of indigents within the state.

Medicaid • One of the simplest approaches would be to extend Medicaid coverage. At present, most legislators and many physicians mistakenly believe that all those indigent and medically indigent are covered by Medicaid. Given that Florida is 49th in the United States in the per capita expenditure by Medicaid and has very tight financial restrictions on who qualifies for coverage, this belief is grossly mistaken. Currently a pregnant woman can qualify only if she is a single parent running a household and has an annual income at approximately 33% of the poverty level. This means her annual family income for four cannot exceed something just less than $4,000. It would be a difficult task to maintain a family of four on $4,000 a year.

The Medicaid program could be expanded rapidly by addition of more state monies to the program that could be matched by the federal government. Under present federal regulations such expansion for a family of four would include incomes up to only $4,400. To include large numbers of mothers and children it would be necessary to request waivers, establish categorical eligibilities and maximize all options available under the federal regulations. Of course, as givers of health care for mother and children, we are concerned that policies or programs be avoided which discriminate against households where both parents are present. We are concerned about family development and integrity.

Another problem presents itself with respect to Medicaid. It currently coveres only about 50% of the usual and customary rate for the physician involved in providing medical care. If this precentage were raised to the Medicare rate, more physicians would participate. An inducement wider to physicians participation has been streamlining the reimbursement process. Presently, 78% of all physician claims are paid within ten days of receipt. The problematic 22% are initially rejected, due most often to errors; of these about 90% are eventually paid.

The 1984 legislative session produced a major piece of legislation that will directly impact on this area. Titled the "Health Care Consumer Protection and Awareness Act," it provides for the following:

Expands the activities of the Hospital Cost Containment Board;

Requires study of indigent hospital care costs and broader based financing;

Expands the Medicaid program to include a "medically needy" program by July 1, 1986;

Studies the feasibility of paying for hospital treatment for patients whose income is below 150% of the poverty level but would not qualify for Medicaid;

Establishes a medical assistance assessment fund to pay for health care services to indigent persons.

Role of private practitioners • The medically indigent usually have some funds for health care but they usually do not have the resources to pay off large medical bills in lump sums, specifically, prepayments to hospitals or physicians. Private practitioners might be able to accept installment payments for services if there were some process to determine which patients are able to pay if allowed to pay by installment. County public health units or county social services might make these determinations. I mention, only to condemn, the practice that occurs in a few areas of the state where pregnant women with excellent health insurance policies are required to pay the full amount of obstetrical care in cash before the seventh month. These women are then left to collect on the insurance policy after the delivery.

Leniency in providing credit to families who are not actually indigent but "temporarily strapped" would be a giant step toward restoring public confidence in our medical care system. Hospitals, too, need to take a hard look at their policy of asking for up front lump sum cash payments from pregnant women some months prior to delivery. These unreflective policies on the part of hospitals and private practitioners seem to contribute to the current backlash against hospitals and physicians.

Many obstetricians and pediatricians have increased the use of nonphysician health care providers in their offices. In doing this, they have been able to more effectively manage their time, are able to see more patients, and thus reduce the overall cost of care to their patients.

Another idea attractive to many people is risk scoring pregnant patients at first visit and offering the low-risk patient a package of care at a much lower cost than the current going rates. This package would involve more self-care and fewer office visits. On the other hand, the high-risk patient could be charged more than the going rate because she requires greater surveillance and more frequent, perhaps weekly, visits. This package might be presented to patients publicly through state organizations as an inducement to stay healthier (not smoking, not drinking) during pregnancy.

Many local physicians' groups such as those in Lee County have for years provided hospital care for poor pregnant women and infants without pay or with only token pay. Other groups — physicians in Ocala and Palatka — have agreed to back up nurse midwifery services for indigent women for token payments. Still others — Broward General in Fort Lauderdale — have raised tens of thousands of dollars to help clinics get started in medically needy areas of the city. In the same locations, retiring physicians have donated the entire inventory of their offices to local clinics in medically needy

areas. All groups performing such outstanding services to indigent patients should be recognized and honored by our state and local medical societies.

County public health units • The traditional public health role has been to serve only indigent women and children. This role is changing in many parts of the state as county public health units offer prenatal and child care services on a sliding scale fee basis determined by what the family can afford to pay. Expanding primary care to eventually cover all Florida citizens under 150% of poverty through the public health units is an option currently being discussed by the Florida legislature. This would insure that all children and pregnant women not covered under some other program would have some sort of care. Such programs would contract with private physicians in many communities and fully integrated and well-planned services would result.

Another important source of primary care in Florida at present is the system of federally funded community health and migrant health centers. These are still in the process of expanding and developing so that they can help capture an ever-increasing portion of the primary care load. Attempts are being made to coordinate and share services in counties that have federally funded primary care centers and county health unit maternity programs. This effort is important if we are to prevent the waste of scarce health care resources.

Retired physicians should be encouraged to volunteer their services at county public health units in the care of pregnant women and children. These physicians are an important but often untapped resource in a retirement state. This past year (1983), the risk management section of the State Insurance Commissioners Office decreed that volunteer physicians, not otherwise actively involved in the practice of medicine in the state, could serve patients at county public health units and be completely covered for malpractice risk under the state risk management coverage as long as they were formally on the payroll as OPS (other personnel services) employees of the county. Few counties have taken advantage of this option but is is an important one to remember for the future.

Children's medical services • Children's Medical Services (CMS), established ten years ago, is a model for the rest of the country in providing medical care for sick children and for certain categories of very high risk pregnant women. However, this program needs to be expanded so that all high-risk women and children can be covered. The locations of services also need to be expanded. There are many patients who have a difficult time, due to transportation problems, gaining access to the centers that provide care. Excellent secondary level hospitals could become established CMS units in areas of great need if the funds were available for them to do so.

Primary prevention programs such as the March of Dimes/Preterm Birth Prevention program (implemented throughout Florida in late 1983) will eventually drastically reduce the number of low birth weight newborns in the CMS neonatal intensive care units. Because of the state's rapid growth and continued expansion, however, improvement of the CMS program will continue to be necessary.

Summary • The medically indigent children and pregnant women are generally healthier than those "truly indigent." We need to make sure that their general good health is secured so that their future employment and participation as active contributing citizens will not be impaired. Outlined were steps that could be taken by private and public health care systems to contribute to that end. Along with these efforts a large dose of public health education is needed to ensure that people will not only learn effective methods of self-care but also how to effectively use the existing health care system when they really need it. All these are challenges and pains of a rapidly growing state.

One sign of progressive health care thinking in Florida is that the legislature this past session enacted the Health Care Consumer Protection and Awareness Act of 1984. We enter the mid-80s with optimism.

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Graying of Florida

Robert E. Windom, M.D., Donald G. Nikolaus, M.D., and John Stokesberry

Physicians are trained to understand the course of life. They attempt to normalize the human, aware that developmental defects predict congenital deformities. Traumatic insults lead to reconstructive surgical procedures. Disease and illness require specific therapeutic programs to completely cure or control the debility within acceptable limits.

The "normal" individuals proceed through life benefiting by the progressive increase in lifespan. Their physiological processes continue with only minimal deterioration. Whatever significantly alters the course is either the result of injury or a specific disease entity.

Physicians and members of allied professions devote most of their time reacting to situations which adversely affect the patient's health. Their goal is a return to normalcy. They have been criticized as interested only in treating and curing patients, not preventing problems. This overlooks their attempts to direct them in maintaining a healthy lifestyle, often ignored when the drive to persist with personal bad habits dominates.

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Ideally the best position for persons in their senior years is to have lived without adverse effects, progressing normally through the process of aging. These fortunate individuals appear and act with little difference from one decade to another. Their demands upon the health care industry are minimal, often only guidance and direction. The second group are those who have survived insults to the system, some leaving residual changes but compensated enough that body function and action are not adversely affected. The third group includes persons in whom compromise in normal function has resulted in some limitation in activity, either mental, physical, or both.

As individuals in these groups progress through life many will require care and attention, assistance of one kind or another even if it offers only control and maintenance. This means community services, home health care, hospice programs, and hospital, nursing home, and Adult Congregate Living Facility (ACLF) beds. At present in Florida there are 150 licensed home health agencies and 21 hospice programs; 62,496 hospital beds, 57,433 nursing home beds, and 36,116 ACLF beds (1,056 ACLFs).

The need appears for more of these services and facilities. A greater percentage of individuals in their senior years, that is over age 65, reside in Florida than in the United States, 17.4% or more than 1.7 million people, compared to 11%. One of four, more than 2.5 million people in the state, are over age 60. Indications are that this population trend will continue. Those delivering health care services have the responsibility to look at the specific problems and react appropriately.

Social changes also affect these older individuals. Death of a spouse has a significant impact

upon their well being. To eventually overcome grief and to manage satisfactory readjustment become essential if they are to continue normal function.

Physicians and members of the allied professions also age. Those who progress normally remain viable and continue serving. It is a waste of talent and ability if they cannot continue their pursuits, and also helpful to their state of mind to continue using their talents constructively.

Health service program • The Senior Friendship Center's Health Service Program in Sarasota exists because a retired physician wanted to continue using his skills.

In 1978 Dr. Irwin Portner suggested to William Geenan, a Catholic lay brother, that he would like to practice medicine on a limited scale. Mr. Geenan had been instrumental in establishing the Senior Friendship Center where older people visit and socialize. Expansion included candlelight dining at a modest cost with others who may have been left alone. The question was: What more appropriate service could there be than medical care for those with limited financial resources who might not otherwise seek help?

Other retired physicians desired to volunteer part time each week working in this endeavor. A limited license through the county health department and state Board of Medical Examiners permitted them to practice under auspices of the county health officer. Liability insurance was provided by the Department of Health and Rehabilitative Services. A location was found and equipment purchased or donated to set up the Health Service. Private support was enhanced by a large donation that completely equipped the clinic. In July 1978 the first patients were seen.

The table illustrates what has occurred. The 14,747 visits indicate that considerable guidance and assistance have been provided. Retired physicians, nurses, social workers, secretaries, dentists and business people have participated.

Table 1. — Senior Friendship Center's Health Service Patient Report

	Average Visits Monthly	Visits Year
1978	68	411
1979	112	1,347
1980	161	1,930
1981	265	3,745
1982	312*	3,437*
1983	323	3,877
Total		14,747

*Closed six weeks

For this type venture to succeed, understanding and cooperation are required with the established medical community. The degree and extent of services provided must be thoroughly established and clearly understood. Periodic conferences must be conducted with related groups. This continuing relationship maintains mutual understanding and allows open discussion, plus the opportunity to alter any function deemed out of bounds. This coordination prevents misunderstandings that might result in estrangement between participants, thus adversely affecting the successful performance of services.

The staunchest supporters of the health service are physicians in the clinics. They are able to maintain their clinical skills and spend time with patients. There is no pressure on their schedule so they can listen and explain, aware that patients sometime fail to understand instructions from their own physicians.

The uniqueness of this program has made it a pioneer in the field of medical care. Drs. Gilbert Dorrance and Stanley Kornblum joined Dr. Portner and after success became apparent with addition of others in the medical and allied fields, accolades were forthcoming from diverse groups. The Governor and Mrs. Graham honored Drs. Portner and Dorrance and Mr. Geenan for their foresight and wisdom in conceiving this type of medical service. Medical publications disseminated reports of activities.

When other counties inquired how the program worked, it was believed that additional medical endorsement was needed. Representatives of the service and physicians from the Sarasota County Medical Society appeared before appropriate committees of the Florida Medical Association. After considerable discussion, a recommendation with specifications was presented to the Board of Governors whose members endorsed it unanimously. This gave credence to the program and its relationship with active medical practitioners.

Six years after conception a group of happy people serve a group of joyous patients. Medical care and information and directions are provided to people heretofore without care or on the fringe of such service. A friendly relationship exists in the medical community. The secret is dedicated commitment by those in medicine, religion, sociology, and business to remain viable in their own personal years of aging and at the same time render valuable service to their peers.

Other community services • The Health Service Program is unique to the Sarasota area but in many communities there are support services available to older people to assist them in preserving their self-respect and avoiding institutional care.

Meals on Wheels helps supply proper nutrition. Balanced meals may be difficult for the individual or couple on a limited income. Socialization is also a vital part of this program.

Senior Centers provide a broad spectrum of services and group activities. Classes in consumer education and protection, cultural activities and referral services are examples. Day care programs for the frail and disabled are a tremendous help for families which need rest and relief, if only temporarily. Activities and socialization supervised and in safe surroundings may be a great help for the impaired elderly. A noon meal is sometimes provided in these programs.

Adult congregate living facilities, adult foster home placement, homes for the aged, and nursing homes are all varying levels of supervision and support to assist the elderly in coping with their problems. Home health care and hospice provide much needed care. The major aim is to keep the elderly in their homes as long as possible.

Dramatic changes have occurred in cardiac and CVA mortality and many factors probably played a part. There have been changes in lifestyle, increased public interest in nutrition, weight loss, exercise programs, stop smoking and drink less. Hypertension is better recognized and controlled. Preventive care must be promoted, however. Tetanus boosters are often neglected in the elderly. Flu shots for those over 65 and with chronic pulmonary and cardiac problems should be given. Pneumovax should be administered when indicated if it has not been given previously.

Periodic examinations should be conducted with the frequency and what should be included left to the physician's discretion. Everyone should have a personal physician to help direct medical care in a complex health care delivery system. The patient should feel free to call, ask questions, be seen, and have ready access to the physician.

Living alone is a common problem among the elderly. Frequently they try to live alone longer than they should. Preparing meals becomes a problem. The Meals on Wheels program has been helpful but needs to be expanded or made more easily accessible.

Physicians frequently see patients in situations where they would be much better off in a congregate living facility. The decision is always difficult and transition from independent to an alternate living situation should be made easier.

Older people should be encouraged to take care of older people. Those who are active and have free time should get involved as volunteers or for income. Changes may be necessary legislatively to make these concepts much more attractive to those who could participate.

Conclusion • Between 1980 and 1990 it is predicted that the number of persons in Florida 65 to 74 years old will increase by 38%, those 75 and older by 84%. By the year 2000, even if the current dollar and bed-per-patient over 65 ratio remain constant, the state will need 96,869 hospital beds, 89,021 nursing home beds, 55,979 ACLF beds, 33 hospice programs, and 233 home health agencies. The state will spend more than $1.5 billion on Medicaid services and more than $43 million on community care for elderly services.

Plans should be in the making to provide the services that will be necessary. Effective programs that allow people to be better cared for in their homes should be encouraged, and self-sufficiency may be necessary. Alternatives to nursing home placement appear more cost effective. Preventive care will be a factor in cost containment. If everyone concerned will help solve problems and give direction, Florida can be the mecca for those in their graying years.

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Rural health care

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Is an adequate level of health care a right? Many people think so. If the right to adequate health care is accepted, equal access is an important corollary. The level of care considered adequate is hotly debated within the context of cost consciousness. Rights, adequacy of care and cost issues are in most vivid focus in the rural areas of Florida. Debating those issues in a rural context within grossly inadequate health care resources is a challenge often overlooked at all levels of program policy and service delivery. And yet, all seem to agree that adequate health care is essential to economic development in rural areas because of its relationship to the quality of life and productivity in the labor force.

What is the definition of "rural"? A rural community has been defined as 50,000 or fewer persons within an area of 31,000 square miles. From a health care resource perspective rural has been defined as a patient/physician ratio of greater than 2,000 to one. There are other definitions. However, in reality the term rural must be defined at least in terms of relative isolation and lifestyle factors as they relate to both the population and the professionals involved. These two factors are interactive and must be taken into account when analyzing a community's needs and potential to achieve an adequate level of health care.

In the geographic area from Florida's panhandle through the north central region and the central part of the state to the Everglades, there are 31 counties with population densities of less than 100 people per square mile. These counties represent over 50% of the land area of our state. The people of these counties deserve the same access and level of health care as other citizens. They are not receiving equity in our health care delivery system and as a consequence rural health care is emerging as important.

Demographics • According to the 1980 census, Florida was the third most rapidly growing state in the nation. While the magnitude of growth over the next 20 years is not expected to rival the 1970-1980 pattern, it is believed that the population will expand at a rate two to three times that of the nation as a whole.

Accompanying this expansion will be a major shift of the population both in rural and urban areas and in the age of the people of the state. The proportion of population over 25 years of age will increase substantially by the year 2000 with the largest growth in the group over 55. A decline in population is projected in the group under 25. In-migration will be the predominant factor in population growth. In rural areas in-migration has a different demographic pattern from migration to urban areas. In-migrants in rural areas are younger, poorer, members of minority groups and have fewer job skills. In addition,

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this group frequently has higher risk factors for morbidity and mortality. Jobs in rural areas typically demand less skill and frequently have the highest risk of occupational injury.

Federal and state involvement in rural health care • The federal government has recognized the special health care needs of rural people and has attempted to design special programs to address those needs. Under auspices of the Florida Department of Health and Rehabilitative Services (HRS) a number of these and other programs have been implemented.

One such program supported by federal funds is called Community Health Centers (CHC). It is designed to support ambulatory health care projects for under- or unserved areas. Grants are provided to public or nonprofit health organizations to deliver services to the people of such areas. In some cases HRS contracts with Community Health Centers to provide services normally provided in county public health units such as the Improved Pregnancy Outcome (IPO) program, Maternal and Child Health and other federally funded programs such as the Supplemental Food Program for Women, Infants and Children (WIC).

During 1983 approximately $23.5 million were provided by the federal government to the state for its CHC program. This funding went to 26 organizations, two of which were the Palm Beach and Sarasota County Public Health Units. The remaining 24 were private, nonprofit organizations with governing boards consisting of consumers, community leaders and health professionals. Private, nonprofit CHC's range in size from a small rural center in the panhandle staffed by a part-time physician and a nurse serving about 1,500 people to a large urban center in south Florida with a group medical and dental practice serving about 30,000 people.[2]

Another federal program which attempts to meet the health care needs of rural people is the National Health Service Corps (NHSC). It was established in 1970 to improve the delivery of health services in underserved areas through placement of health professionals and other health care resources in rural areas. This program has two options. In one the federal government pays the salaries of health professionals and provides administrative/financial management assistance. The community manages the practice and provides office space, equipment, supplies and support staff with federal financial assistance. A second option places the professional in a private practice setting in a medically underserved area while he/she meets his/her federal health service obligation.

Under a contract with the National Health Service Corps, HRS is responsible for the recruitment, placement and management of NHSC health professionals. First priority is in rural areas with a high proportion of indigent people. During the past year, nearly 50 new health professionals were placed in rural areas in Florida. Presently 120 National Health Service Corps providers are assigned to Florida, 81 are federal employees. The distribution of Corps personnel is noted in Table. 1.[2]

These 82 health providers are located at 54 sites; six physicians and four dentists are in county public health units; two psychiatrists in mental health centers; the remainder are in NHSC free-standing sites or migrant and community health centers. In addition, 38 physicians selected the private practice option to complete their payback obligation and are located in rural Florida.

Other special purpose programs funded by the federal government include Migrant Health Center (MHC) and Health Underserved in Rural Areas (HURA). The purpose of these programs is to support the delivery of quality health services for migrant and seasonal farm workers and their families. Centers provide diagnostic, treatment and preventive services and may include dental care, nutrition counseling and environmental services.

There is a federally funded program to coordinate rural health services. The Rural Health Initiatives (RHI) assists in development of health care systems by managing activities of a number of existing federal programs operating in the rural area. Programs coordinated and integrated include CHC, NHSC, and MHC.

In addition to federally funded activities, HRS supports its own services to rural citizens through ongoing county public health units and Children's Medical Services (CMS). Both public health and CMS provide outreach clinic and nursing follow-up to rural areas. The public health services are directed toward the general population while CMS focuses on chronically ill children. Both services provide or coordinate care for Medicaid clients of HRS.

Problems • With the recent diagnostic attention to the problems of rural health care as with close attention to a complex patient, the closer we look the

Table 1. - National Health Service Corps Health Providers.

39	Family Practice or General Practice Physicians (M.D.s, M.D.O.s)
2	Psychiatrists
1	Pediatrician
1	Podiatrist
30	Dentists
4	Certified Nurse Midwives
3	Nurse Practitioners
1	Nutritionist
1	Pharmacist

more unsolved problems we find. These include lack of health care facilities, health care professionals, transportation and absence of financial incentives to solve those problems.

Financing may be the biggest obstacle. Private health insurance tends to be limited because many residents are employed in agriculture or are self-employed and have little or no access to group health insurance plans. The Health Maintenance Organization (HMO) option available in many urban areas could not be viable financially in a rural, sparcely populated area. Public financing through Medicaid and Medicare has not compensated for the inadequacy of health care because both programs assume a supply of professional manpower and health facilities which do not exist in rural areas. From a socioeconomic perspective these programs are designed to deal with the health care needs of the urban poor. For example, Florida's Medicaid virtually precludes eligibility for intact families. Approximately 70% of rural families are intact as compared to 39% of those in the inner city, thus the rural poor fail to meet the eligibility requirements for Medicaid.[3]

The distribution of physicians in rural areas has traditionally been a problem. Lack of peer contact and of hospital facilities similar to those in which they were trained or in which they had previously practiced discourage physicians from locating in rural settings. Eight counties in Florida have no hospital and many counties have small hospitals which because of their size cannot provide the range of diagnostic and therapeutic modalities available in more urban areas. Rural practitioners often cannot find appropriate space and must bear the expense of building a health care facility.

Solutions • Several programs seem to be working toward resolution of the health care shortage in rural Florida. Physicians in some medical schools are being trained in rural areas. The University of Florida College of Medicine, Department of Community Health and Family Medicine, requires a medical student rotation in rural health settings as part of the clerkship. Nationally, many family practice residency training programs have begun to require or provide elective rotations for physicians in nonurban health care settings. Studies show that residents tend to practice in settings in which they have trained. Rural areas are increasingly working more closely with medical schools to provide preceptorships for medical students and to decentralize residency education programs by using rural health care facilities. With the oversupply of graduates of U.S. medical schools, new professionals will be seeking practice sites outside the standard urban setting. For example, in the last two years approximately 40% of new family physicians graduates have established practice in rural towns of 2,500 - 25,000 and 10% have settled in communities smaller than 2,500 population.[4]

A special initiative of the Florida Department of Health and Rehabilitative Services has attempted to address one of the most difficult and costly inadequacies in our state's health care system. With funding from the Robert Wood Johnson Foundation and the Medicaid program, HRS has developed a demonstration project, REACH, which decentralizes follow-up for rural tertiary care patients. Rurally based, specially trained nurses acting under physician-directed protocols work with families of chronically ill children to locally manage care and reduce the unnecessary and expensive use of tertiary facilities and services.

The problems of rural health care are not resolved easily. The economic barriers will require political solutions. Rural communities must develop an awareness of their common problems. The urban biases of public and private third party payment systems must be eliminated. Local cooperative efforts must be made to provide viable practices for health professionals in rural communities. Rural health care facilities, where they exist, must be viewed as a multipurpose resource to be used for coordination of a variety of public and private health services.

The Department of Health and Rehabilitative Services must specifically address rural health care services in its programs, including Public Health Services, Children's Medical Services, Medicaid and Comprehensive Health Planning. The Departments of Insurance and Transportation must review their regulations and provide for the elimination of barriers to adequate health care so that the citizens of rural Florida have access equal to that of urban citizens.

If adequate health care is seen as a right, and if the rural people do not have equal access to such care, then it is our duty to assure the barriers to equal access are eliminated and that rural communities are assisted to achieve their health care goals.

References

1. 1980 Obers BEA Regional Projections, U.S. Department of Commerce, July 1981.
2. Primary Care Health Program, Health Program Office, HRS, State of Florida, April 1984.
3. Kane, W.: Rural Health Care, JAMA 240:2647, 1978
4. American Academy of Family Practice, Reprint Number 1551, 1984.

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Florida Emergency Medical Services — A proud past and a bright future

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In the early 1960s, emergency medical services in Florida were similar to that in many parts of the country. Ambulance conveyance was mainly by funeral homes, the epitome of conflict of interest. With passing of the Florida Highway Safety Act, the Florida legislature in 1966 amended Statute 877 establishing an Emergency Medical System. The Act created power to license ambulances and to define the role of ambulance attendants.[1] For the first time, standards for attendants were set up, requiring completion of the American Red Cross First Aid Course. In 1969 the Division of Health eastablished an EMS program directed toward planning and evaluating elements in the emergency medical services system. Funds were provided by the Governor's Highway Safety Commission to conduct the first survey of existing resources. In the monograph of the Emergency Medical Services in Florida (1970), it was pointed out that ambulance attendants were inadequately trained and ambulances poorly equipped. In addition, no communication system existed. Public support and tax support for developing an emergency medical system were inadequate. In 1971, as a result of this survey, Statute 877 was amended by the legislature.[2] Provisions were made to: (1) establish an 80-hour emergency medical technician (EMT) training course, (2) initiate a statewide registry of EMTs, and (3) establish a state EMS Advisory Council as well as community councils.

The first EMS Medical Director was appointed in 1971. In 1973 the Florida Emergency Medical Services Act was passed.[3] Results were: (1) development of a state EMS plan, (2) minimal standards for vehicle licensing, (3) periodic inspection of vehicles, (4) minimal standards for personnel certification, (5) fee schedule for licensure and certification, (6) penalties for violation of provisions of this act, (7) EMS Advisory Council, and (8) matched fund programs to counties for EMS development.

In the following two years $2.4 million were distributed for EMS development on the county level. In 1974, the legislature passed the Florida Emergency Telephone Act creating a funding mechanism by which counties could enact the 911 system. The next major legislative initiative was in 1977 when the EMS Act of 1973 was amended to include advanced life support services. In 1980 advanced life support services were required to contract with a medical director.[3]

As can be seen, in less than 20 years the prehospital EMS system moved from extraordinarily primitive beginnings requiring only first aid courses for attendants to a sophisticated ALS based system. During this period the concept of EMS was entirely related to prehospital agencies and little, if any, consideration was given to the hopsital phase. In 1979 the Florida Medical Association led the way in assessing critical care facilities in hospitals, compiling data from volunteer questionnaires completed

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by Florida hospitals.[3,4] It produced an excellent profile of the abilities of hospitals to function in the major areas of emergency medicine. Referral patterns within the state were mapped out. The status of specialty staffing was enumerated and the ability to meet certain preset standards was assessed. In 1981 the legislature appropriated funds for statewide emergency medical service and critical care analysis. For the first time, the governing body recognized that EMS involved patient care from the time the emergency occurred until the patient left the hospital, hopefully to resume his normal lifestyle. EMS, then, was transformed to EMSS, Emergency Medical Services Systems, which includes transportation, communication, public education, prehospital medical direction, emergency department care, continued hospital care, rehabilitation, and community based services to aid the patient as he reenters his normal environment.

In 1982 the legislature, additionally, passed far-reaching legislation regarding verification of trauma centers in the state, placing it among the leaders in attempting to establish a network of training facilities to improve the care of the injured patient.[5,6] Also, in 1982, Chapter 401, which included the Emergency Medical Services Act of 1973, was reviewed by the legislature as part of the Sunset Law provisions.[7] Some changes strengthened its provisions. In 1983 the Florida Medical Foundation-Emergency Medical Services Project report was published and presented to the HRS-EMS office. For the first time in several years, a state medical director was appointed. Amendments to the Florida Statutes in 1984 established an EMS Advisory Committee which had its initial meeting on February 15, 1984. In addition, the state office set up numerous resource panels which will include over 100 individuals to assist in evaluating and making of policies for emergency medical services.

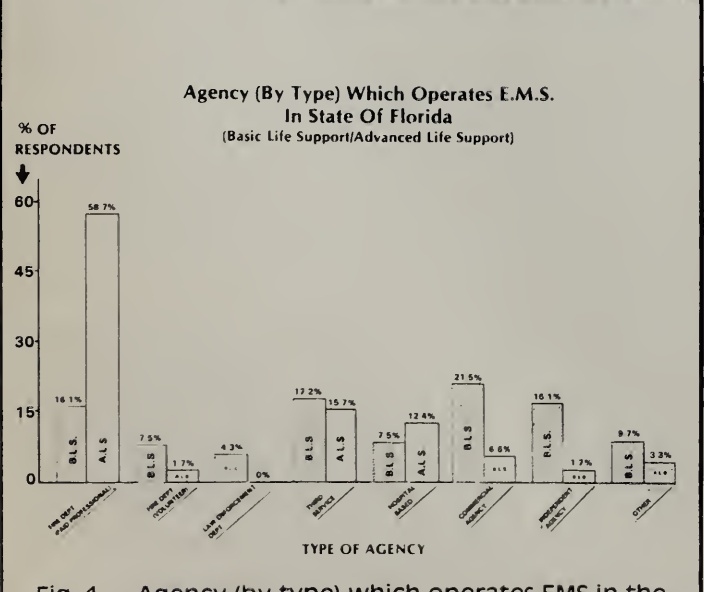


Fig. 1 — Agency (by type) which operates EMS in the state of Florida.

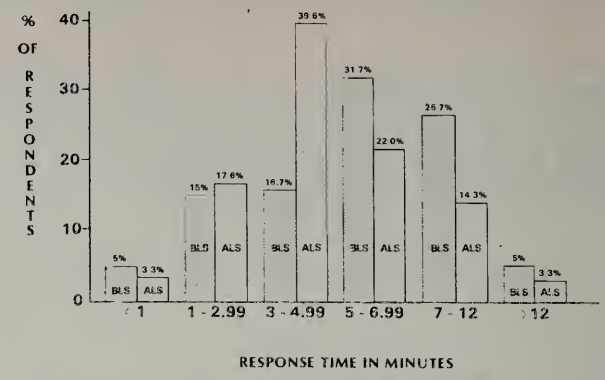


Fig. 2 — Average response time of EMS units (Basic Life Support/Advanced Life Support).

Present • This period in EMS is an exciting time, pivotal in transition from an illustrious past to the exciting future. At present 246 EMS agencies exist in the state. Those which operate the EMS system are shown in Figure 1. More than half are professional fire departments. Financial support is shown in Figure 4. During the period 1981-1982, these 264 EMS agencies made 1,156,060 responses and transported 577,539 patients. The average response time in minutes is given in Figure 2.

The EMS agencies receive notification mainly by telephone. At the time of publication of the report 25 of 64 (39%) counties possessed three-digit 911 access capabilities (Fig. 3).

Florida has 240 hospitals. During the period 1981-1982, there were 1,670,989 admissions of which 201,102 (12%) were critical care of EMSS patients. The specialty services were well represented. The number of hospitals having a certain specialty as reported in the survey and the percent of number of hospitals responding having these specialties are shown in Table 1.[3]



Fig. 3 — State of Florida 911 program survey response.

Table 1 — Specialties in Florida Hospitals

SPECIALTY	HOSPITALS WITH THE SPECIALTY #/N	%	TOTAL NUMBER OF SPECLTS	IN-HOUSE 24 HRS/ DAY (%)	ON-CALL WITHIN 30 MIN. (%)	TOTAL TRAINEES
Anesthesiologist	165/179	92.2	1051	5.1	88.0	86
Cardiologist	162/176	92.1	1460	1.7	83.6	27
Cardiothoracic surgeon	134/160	83.8	700	-	71.2	15
Emergency physician	162/174	93.1	1179	82.7	25.0	40
Gastroenterologist	142/169	84.0	762	1.2	77.9	13
General surgeon	194/195	99.5	2591	3.7	92.6	218
Hand surgeon	67/125	53.6	229	1.2	48.4	3
Infectious disease physician	93/138	67.4	184	-	54.0	7
Internal medicine physician	183/190	93.6	4009	4.3	88.1	348
Intensivist	9/104	8.7	28	2.6	8.6	3
Neonatal/ perinatologist	33/115	28.7	101	5.2	18.1	6
Nephrologist	130/161	80.8	506	-	69.1	5
Neurologist	155/173	89.6	715	0.6	81.3	27
Neuroradiologist	27/115	23.5	91	0.7	23.4	29
Neurosurgeon	129/163	79.1	488	1.2	71.3	17
Obstetrician/ gynecologist	176/187	94.1	2094	5.4	86.4	156
Ophthalmologist	171/179	95.5	1544	1.1	86.0	43
Oral surgeon	151/169	89.4	732	1.2	79.1	19
Orthopedic surgeon	171/181	94.5	1893	2.3	87.1	66
Otorhinolaryn-gologic surgeon	149/166	89.8	709	1.2	79.1	15
Pathologist	186/189	98.4	740	1.1	88.8	78
Pediatrician	150/172	87.2	1736	4.5	76.5	180
Pediatric cardiologist	31/114	27.2	52	0.6	21.2	7
Pediatric surgeon	41/118	34.8	65	0.7	28.1	5
Physical medicine/ rehabilitation physician	76/132	57.6	140	0.6	42.1	1
Plastic surgeon	136/162	84.0	759	0.6	73.8	11
Psychiatrist	162/178	91.0	1501	1.7	82.9	74
Pulmonary medicine physician	136/163	83.4	437	0.6	76.5	12
Reimplantation surgeon	15/104	14.4	65	1.3	16.5	2
Traumatologist	9/104	8.7	130	-	8.0	-
Urologic surgeon	173/181	95.6	1284	1.7	86.1	25
Vascular surgeon	110/137	80.3	578	1.2	67.9	5
Clinical pharmacist	74/124	59.7	295	42.1	54.8	6
Medical toxicologist	9/ 96	9.4	12	1.4	9.1	-



Fig. 4 — Income and support for EMS agencies (Basic Life Support/Advanced Life Support).

Within HRS the EMS office has been reorganized to have an administrator, Larry Jordan who has been effective in bringing it from the status of a licensing and certification agency to its potential for planning and initiating important initiatives. The presence of a medical director allows medical input regarding these decisions and assures the coordination of prehospital and hospital efforts. Advisory councils and resource panels are at work on daily problems. The FMF-EMS report outlined a five-year plan in terms of the entire scope of EMS as well as goals and objectives in all areas. The state office has translated guidelines into action items with timeframes, assignment of tasks to various organizations and agencies, methodology, and source of funding. In parallel, the Trauma Verification Law is addressing the issue of trauma centers in the state. Thus far, 14 centers have been verified and others will be applying for verification in the near future (Fig. 5).

Future • Implementation of the five-year plan will involve other state agencies, Florida Medical Association, American College of Surgeons Committee on Trauma, and Emergency Medical Services Educators of Florida as well as provider organizations.

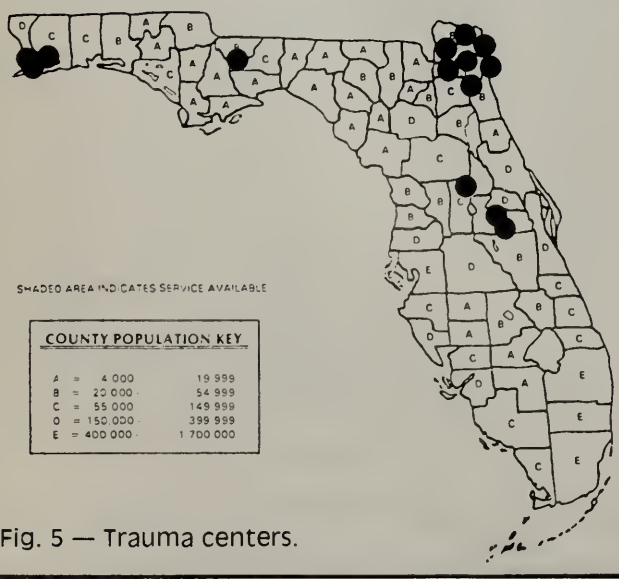


Fig. 5 — Trauma centers.

Each will be keyed into the process via the Advisory Council or resource panels. Input will be to the EMS office for implementation. All seven areas of EMS will be addressed, i.e., cardiac, poisoning, neonatal pediatric, spinal cord injury, burn, trauma, and psychiatric. Overall goals are:

1. Public education in each of the areas of EMS.
2. Legislative education as to the importance of these items and the priorities for funding and legislative action.
3. Centralized data collection in each of the areas of EMS to assess the quality of patient care, cost, and outcome.
4. An innovative method of financing EMS which will not depend on ad valorem taxes.
5. Central locators in each of the areas of EMS who will have a number of available beds in each of these areas which may be utilized by hospitals and patients needing these resources.
6. Uniform transfer procedures manual including both administrative and medical protocols.
7. Statewide 911 system for notification of EMS agencies by those needing care.
8. Effective and economic communication systems.

Specific recommendations have been made in each area of EMS. Qualifications of agency medical directors have been published as well as the need for medical directors in basic life support systems. Specific guidelines have been established for various levels of hospitalization in cardiac, psychiatric, rehabilitative, trauma and burn care, AMA standards for accreditation of paramedic training centers adopted and future EMT standards approved. Testing and recertification as well as continuing medical education for EMS prehospital personnel have been addressed.

With the traditional seven areas of EMS the following plans are to be implemented:

Burns • The burn hotline, which will control beds and provide physicians, will be the means to contact burn centers in the state. Public education and

outreach programs will be implemented for hospitals and the public.

Cardiac • "Citizen saver" or citizen "CPR program" will be offered. Possible training of EMTs in defibrillation is being considered. Medical direction for all basic life support units is a high priority goal.

Pediatric neonatal • A statewide program for neonatal and pediatric emergency critical care trauma centers is now being implemented. Public education particularly in areas of accident prevention is a high priority. Seat belt legislation has already proved an effective tool as infant mortality dropped from 26 the year prior to legislation to 11 in the first year of enactment.

Poison and toxicology • Guidelines for identification, development and operation of poison control and information centers are currently being formulated. A statewide toxicology resource panel has been appointed.

Psychiatric drug and alcohol • Training and education are being encouraged in psychiatric drug and alcohol area for law enforcement officers, paramedics and EMTs.

Spinal cord injury • Integration of spinal cord injuries more into the major trauma schema will benefit both programs.

Trauma • Modification of the law to include funding mechanisms for trauma center support is the highest legislative priority. Requirements that the transport of patients to a trauma center, based on the extent of their injuries on site, must also be included in revision of the law. Categorization of centers must be legislated if a true "trauma network" is to become a reality.

Summary • The past several years have been exciting in the history of Florida EMS systems. For the first time the two components, prehospital and hospital care, have been considered as one and attempts made to form one system. Involving the public in activities such as first aid and CPR is being emphasized and augmenting ambulance equipment and training crews continued. Integration of aircraft more rationally into this system is priority. Communication, beginning with a statewide 911 system, continues to be advocated. Major emphasis is upon delivery of patients to the appropriately staffed and equipped facility.

Florida has always been a national leader in emergency medical services and the recent renaissance in activities not only will maintain that leadership but make the state preeminent in terms of resources, personnel and planning. We have a proud past, and based upon the scope of the five-year plan EMS leaders have not taken a resting course.

An EMS Glossary

Medical Director — A physician licensed under Chapter 458 or Chapter 459 employed or contracted by a licensed Emergency Medical Services provider who gives medical supervision not including administrative and managerial functions for daily operation and training pursuant to Chapter 401 (EMS law).

Basic Life Support — Treatment of lifethreatening medical emergencies through the use of techniques such as patient assessment, cardiopulmonary resuscitation, splinting, obstetrical assistance, bandaging, administration of oxygen, application of medical antishock trousers, and other techniques listed in the Emergency Medical Technician Basic Training Course Curriculum of the United States Department of Transportation. Basic life support may also include other techniques approved and performed under conditions specified by rules of the Department. Agencies classified as basic life support agencies are not required by state law to have a medical director.

Emergency Medical Technician (EMT) — An individual who has proficiency practicing basic life support. This proficiency is gained through an 80-hour course published by the United States Department of Transportation. The EMT must be licensed in Florida. Such license is given by successful completion of a state examination.

Advanced Life Support — Treatment of lifethreatening medical emergencies through the use of techniques such as endotracheal intubation, administration of drugs or intravenous fluids, telemetry, cardiac monitoring, cardiac defibrillation, and other techniques prescribed by the medical director. The agency licensed to administer advanced life support must by state law employ a medical director.

Paramedic — An individual proficient in the techniques of advanced life support. Training includes 80-hour EMT offered by the United States Department of Transportation and in addition a program equivalent to this most recent course as approved by the HRS-EMS office. The paramedic must successfully complete the certification examination given by the state of Florida. Certification may be of variable length and in some areas may be as much as 1,000 - 2,000 hours of training.

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Acquired Immunodeficiency Syndrome in Florida — a review

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ABSTRACT: Acquired Immunodeficiency Syndrome (AIDS) is epidemic in the United States with over 5,000 cases and a steady increase in new cases over the past three years. AIDS is manifested by Kaposi's sarcoma and/or opportunistic infection in a previously healthy person. Over 95% of patients can be classified into one or more clearly defined risk categories. The disease is most likely caused by a viral-type transmissible agent(s). This paper reviews clinical features, diagnosis, treatment, and prevention. Patterns of AIDS in Florida are compared to the remainder of the United States.

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The Acquired Immunodeficiency Syndrome (AIDS) is defined as the presence of certain opportunistic infections, e.g., *Pneumocystis carinii* pneumonia and/or Kaposi's sarcoma, in a previously healthy person.[1] Individuals with known causes of immunosuppression, e.g., cancer chemotherapy, carcinomatosis, corticosteroid therapy, are excluded even if they develop opportunistic infections.

AIDS was first recognized as a distinct entity in the United States and has now been identified in over 20 countries.[1] In the U.S., the disease has largely been confined to four high risk groups: male homosexuals (72% of cases), intravenous drug users (14%), Haitians (4%), and hemophiliacs (0.7%).[1] It has been reported among female sexual contacts of patients, in infants born of parents with AIDS (or in a risk category), and in recipients of massive blood transfusion.[2-7] Less than 5% of cases do not fit in a clearly identified risk group.[1]

Clinical manifestations

Kaposi's sarcoma • This is a tumor of endothelial cell origin now recognized as a major manifestation of AIDS. It is observed in approximately one third of cases[8] and is more common in homosexual men (93%) than in other groups at risk (i.e., Haitians and intravenous drug users).[9] Patients with Kaposi's sarcoma are usually less severely immunosuppressed than those with opportunistic infection.

Kaposi's sarcoma is commonly found on the skin, especially the extremities and soles of the feet. The dark red to blue-purple plaques or nodules are painless and do not itch. Lesions can involve lymph nodes, gastrointestinal tract, conjunctiva, and visceral organs.

The diagnosis is made by biopsy of suspicious skin, mucous membrane lesions, or persistently enlarged lymph nodes. Skin lesions in blacks are darker in color and can be mistaken for keloids. Endoscopy is necessary to document involvement of the gastrointestinal tract.

The effectiveness of cytotoxic chemotherapy and/or immunostimulant drugs such as interferon and interleukin-2 are still being assessed; perhaps 20% or more of patients will achieve temporary response or remission.[10,11] These patients have a better prognosis than those with opportunistic infection.[8,12]

Other tumors or cancers such as Burkitt's lymphoma and maligant lymphoma of the central nervous system are reported in a few patients.[13,14]

Opportunistic Infections

Parasitic Infections

Pneumocystis carinii pneumonia • *P. carinii* pneumonia is the most common (57% of cases) and frequently fatal opportunistic infection in AIDS. The onset is often insidious, developing over two to ten weeks. Symptoms include fever, nonproductive cough, and progressive shortness of breath. A chest x-ray may be normal early in the course of the disease but later shows patchy infiltates. Arterial blood gases show mild to moderate hypoxemia. Diagnosis requires transbronchial biopsy or bronchial washings, which reveals organisms when stained by methenamine silver.[15,16]

P. carinii pneumonia requires prompt diagnosis and treatment. Trimethoprim (20 mg/kg/d) and sulfamethoxazole (100 mg/kg/d) are used intravenously or by mouth for at least three weeks. Hypersensitivity reactions and/or leukopenia occur in at least one third of individuals.[17] Pentamidine (4 mg/kg IM × 14 d) is the alternative drug and is available only through the Centers for Disease Control.[18] Adverse effects of pentamidine include renal abnormalities, painful abscesses at the injection site, and hypotension.[18] Chemoprophylaxis with trimethoprim-sulfamethoxazole prevents relapse in cancer patients,[19] but similar use in patients with AIDS may be limited due to adverse reactions to the drug.

Toxoplasmosis • Central nervous system toxoplasmosis results from reactivation of latent *Toxoplasma gondii* infection. CNS toxoplasmosis is one of the most frequent opportunistic infections in Haitians and is less common in homosexual men.[20,21] Higher rates of exposure to the organism in Haitians (90%) vs male homosexuals (38%) probably accounts for this difference.[22,23]

Central nervous system toxoplasmosis causes diffuse encephalopathy, meningoencephalitis, and/or brain abscess. Individuals complain of nonspecific symptoms followed by headache, paralysis, and sometimes seizures. A CT scan of the brain usually shows ring-enhancing lesions. Brain biopsy is necessary for definitive diagnosis.[20,24] Treatment consists of sulfadiazine (4 gm/d) and pyrimethamine (100 mg loading dose followed by 25 mg/d). Antibiotics should be continued four to six weeks after the patient has shown definite evidence of resolution both clinically and radiographically. Recurrence after discontinuing therapy is universal and suppressive therapy should continue indefinitely. One such regimen currently under investigation consists of Fansidar (pyrimethamine plus sulfadoxine) one tablet two times per week.[24] There is no effective treatment for patients allergic to sulfonamides.

Cryptosporidiosis • *Cryptosporidium/spp.* is a coccidial parasite that lives in the gut and is capable of producing chronic and sometimes overwhelming diarrhea in patients with AIDS. Such individuals have up to 10-20 watery stools per day leading to severe dehydration, wasting, weight loss, and malabsorption.[25,26]

Diagnosis of cryptosporidiosis requires special techniques to detect oocysts in the stool. Stool samples should be clearly labelled to check for this organism and processed by sugar flotation and/or modified acid-fast stain. Diagnosis can also be made by endoscopic biopsy of the duodenum or acid-fast staining of mucous from the "string test" (Enterotest).[26]

Treatment includes adequate fluid replacement and correction of electrolyte disturbances. Hyperalimentation may be necessary in severe cases to "rest" the bowel. Although antibiotics had previously been totally ineffective for chronic cryptosporidiosis, spiramycin (Rovamycine,® Rhone Poulenc, Montreal) has been reported as beneficial.[27,28] We are using spiramycin (3-4 gm/d in divided doses) for at least four weeks in patients with AIDS and cryptosporidiosis.[28] Most will show improvement but continue to shed cysts in the stool. Spiramycin must be used with permission of the Food and Drug Administration and is available from the Centers for Disease Control or Tropical Medicine and Travelers Clinic.[27,28]

Disseminated *Strongyloides* (nematode parasite) occurs in patients, is diagnosed by stool examination or string test (Enterotest) and is treated with thiabendazole (25 mg/kg twice daily × 3-5 days). Retreatment is frequently necessary. *Isospora belli* is a coccidial parasite that causes enteritis with a wasting syndrome in Haitians with AIDS. Oocysts of *Isospora* are rare in stool but they are usually found on the string test.[26] The enteritis is treated

with a prolonged (i.e. four-week) course of trimethoprim-sulfa.[18] *Entamoeba histolytica* and *Giardia lamblia* are found frequently in male homosexuals but rarely cause life-threatening disease.

Fungal Infections

Candida • Oral candidiasis, an early manifestation of AIDS, is frequently observed prior to onset of Kaposi's sarcoma or opportunistic infection. Gray/white patches or ulcers in the oral cavity ("thrush") are painful and make it difficult to swallow. Esophagitis is more severe and causes dysphagia or retrosternal pain. Upper endoscopy is necessary to document the condition.[29]

Treatment of candidiasis consists of oral nystatin (500,000 units every four hours) or ketoconazole 200 mg/d.[29] Bone marrow depression may complicate prolonged therapy with ketoconazole. Idiosyncratic hepatic failure occurs rarely.[30] Esophageal candidiasis may require therapy with amphotericin B.[29]

Other fungal infections include *cryptococcosis*, *aspergillosis*, *histoplasmosis*, and *coccidiomycosis*.

Viral Infections

Cytomegalovirus (CMV) • Exposure to cytomegalovirus is extremely common in risk groups for AIDS including homosexual men. CMV causes interstitial pneumonia, ulcerative gastrointestinal lesions and diarrhea, retinitis, hepatitis, skin rash and encephalitis.[29] Viral isolation or biopsy material showing typical viral particles are consistent with this diagnosis. Serologic diagnosis is unreliable. There is no effective drug treatment.

Herpes simplex • This virus is classified as opportunistic when it causes chronic (greater than two months duration) or widespread disease. It causes extensive genital or perirectal ulcerations in patients with AIDS.[31] Presumptive diagnosis is by identification of multinucleated giant cells on scraping from lesions or definitive diagnosis by positive viral culture. Treatment with intravenous acyclovir (5 mg/kg/ every eight hours for seven days) reduces the duration of illness.[32]

Human T-cell leukemia and/or lymphadenopathy - associated virus • Human T-cell leukemia/lymphoma virus (HTLV) is a retrovirus with a special affinity for lymphocytes. Retroviruses have the unique ability to replicate "backwards" by using reverse transcriptase to make DNA from RNA. This viral DNA incorporates into human DNA and alters the genetic code.

Recently it has been suggested that HTLV type 3 (United States) or lymphadenopathy-associated virus (LAV) (France) may be the causative agent of AIDS. This virus, or antibody to it, has been found in the majority of AIDS patients, in patients at high risk, and in a few otherwise normal homosexual men.[33-35] Antibodies to HTLV type 1 were present in the Caribbean, southeastern United States and Japan prior to the current epidemic of AIDS. The role of retroviruses in AIDS is being investigated.

Bacterial Infections

Mycobacterial • Disseminated *Mycobacterium tuberculosis* infections are not considered opportunistic yet 80% of Haitians with AIDS have *M. tuberculosis* before other manifestations develop.

Mycobacterium avium-intracellulare invades lymph nodes and other reticuloendothelial tissue causing lymphadenopathy and a wasting syndrome.[36] This *Mycobacterium* sp. is resistant to the common antituberculous drugs. Treatment protocols are still under investigation.

Other bacterial infections include *Listeria monocytogenes*, *Nocardia asteroides* and recurrent *Salmonella* bacteremia. New opportunistic infections will probably be added to the list as more is learned about AIDS.

Laboratory abnormalities • Leukopenia with a white blood cell count below 5,000 and lymphopenia or total lymphocyte count of less than 1,500 are often present. Careful differential may show an increased number of monocytes. Anemia and thrombocytopenia may be present. In vitro response to mitogens is abnormal. There is skin test anergy to several antigens incuding candida, trichophyton, tenanus, mumps, and tuberculin.[37] There is a decrease in T-helper lymphocytes and a corresponding low ratio of T-helper (OKT4) to T-suppressor (OKT8) cells (normal 1.1-3.5).

B cell abnormalities are common with a nonspecific increase in IgG, IgA and IgD antibodies.[38] IgM antibodies are usually within normal limits. Increased thymosin, a hormone that stimulates the growth of T-lymphocytes, occurs in over half the patients. Antibodies to multiple infectious agents are detected, e.g., hepatitis B, CMV, EBV (Epstein-Barr virus), and syphilis. In Haitians there is an increase in immune complexes which has not been generally observed in other risk groups.[21]

AIDS in children • Infants with AIDS have been reported from New Jersey, New York, California, Montreal and Florida.[4,5,39-42] The majority have been born to mothers with known risk factors. A few have had a history of blood or blood component

transfusion prior to onset of illness. The diagnosis is complex and a provisional case definition has been published by CDC.[43] Known congenital immune deficiencies as well as congenital infection must be excluded before a case can be designated as AIDS.

Other infants have been described with an AIDS-like illness.[4,39] These have clinical and immunological characteristics similar to those with AIDS but do not have opportunistic infections or Kaposi's sarcoma.

Fifty-seven children with AIDS have been reported to CDC as of June 1984.[44] In this group, 29% are white, 50% black, and 21% of Hispanic origin.

Infants usually have clinically apparent disease in the first year of life with a mean age of onset of three months.[4] The incidence in males and females is equal. Affected siblings, with as many as three affected children from a single mother, have been reported.[4,42]

The main clinical and immunlogic findings in children with AIDS are shown in Table 1. Most infants with AIDS or an AIDS-like illness present with four or more of these clinical findings. *Pneumocystis carinii* pneumonitis is the most common opportunistic infection and occurs in about 80% of confirmed cases.[44] In addition, several children have persistent interstial pneumonitis and lung biopsy reveals a lymphocytic infiltrate. Progressive capillary alveolar block and chronic lung disease are sequelae.

Recurrent bacterial infections include *Streptococcus pneumoniae*, *Hemophilus influenza* and *Salmonella* species. Oral candidiasis responds poorly to nystatin or gentian violet while oral ketoconazole is effective in most cases. Other opportunistic infections have been reported and are similar to those occurring in adults. Disseminated Kaposi's sarcoma has been reported in two children.[45]

Table 1. — Clinical and Immunological Findings in Infants and Children with AIDS.

Failure to thrive
Persistent oral candidiasis
Persistent interstitial pneumonitis
Recurrent or chronic diarrhea
Hepatosplenomegaly
Lymphadenopathy
Recurrent bacterial and viral infections
Elevated serum immunoglobulins (particularly IgG)
Decreased number of T-cells
Decreased number of T-helper cells
Inverted T-helper/T-suppressor cell ratio
Decreased lymphocyte response to mitogens

Immunological abnormalities are similar to those described in adults. Absolute lymphocyte counts are usually normal in contrast to the lymphopenia reported in adults. In longitudinal follow-up, immune abnormalities persist.

The prognosis is not certain and overall mortality rates are not available; however, of the 19 children with AIDS identified in Florida since 1980, 89% have died. Infants with an AIDS-like illness appear to have a lower mortality rate.[4,5]

Epidemiology • AIDS has become the number one priority of the United States Public Health Service. As of July 16, 1984, CDC reported 5,214 cases in the United States clustering in the major coastal cities, New York, San Francisco, Miami, Los Angeles, and Houston. The number of cases doubles every nine months. The average age at onset is 35 years. The incubation period ranges from a few months to four years.[6] Approximately 40-50% of patients die within two years of diagnosis and 80-90% after this time.

AIDS in intravenous drug users, hemophiliacs, and recipients of massive blood transfusion results from exchange of blood products. In male homosexuals it results from specific sexual practices that lead to transfer of secretions from one person to the bloodstream of another, e.g., anal intercourse receiving.[46,47]

Transmission to infants most likely occurs transplacentally or perinatally from the mother. A few cases have occurred as a result of blood or blood product transfusion.[6,41] Studies indicate that mothers of AIDS infants have abnormal cellular immunity although not all have AIDS.[5]

In Florida as of August 1984 over 400 cases have been reported.[48] Five cases were reported in 1980, 14 in 1981, 72 in 1982, and 163 in 1983. The disease is not uniformly distributed throughout the state. Four counties, Dade, Monroe, Broward, and Palm Beach, account for 82.5% of reported cases. Miami had 142/162 (87.7%) of Dade cases, Key West reported 15/16 (93.8%) of Monroe cases, Ft. Lauderdale reported 22/32 (68.8%) of Broward cases, and nine out of 16 (56.3%) cases reported in Palm Beach County were from Belle Glade and Pahokee.[48]

A comparison of reported cases according to age, race and sex in Florida to the United States reveals striking differences. Florida has a higher proportion of cases among those younger, black, and females. This is partially explained by the percentage of Haitian cases (28%) vs. the national average (4%). The overall case fatality rate (52%) in Florida is higher than the national figure (43%). These rates reflect a higher proportion of individuals with opportunistic infections.[7]

No one knows why a small percentage of Haitians, both in Haiti and the United States, are victims of AIDS.[20,49,50] Retrospective autopsy data

reveal the first cases appearing in Port au Prince in December 1978[51] and the first cases in Los Angeles in March 1978, suggesting that new agents were introduced into Haiti and the United States at about the same time. None of the current hypotheses, multiple infections, immunsuppressive substances, and malnutrition, adequately explains the appearance of AIDS among Haitians with no other risk factors. Cofactors such as arboviruses, i.e., dengue and early exposure to infection(s) transplacentally, are being studied.

We believe AIDS has a much broader Caribbean base than is currently appreciated. AIDS has been reported from other Caribbean countries, e.g., Dominican Republic, Puerto Rico and Trinidad. Hispanics not listed by country of origin include many Caribbean people and account for 14% of cases in the United States while Haitians only account for 4%. The majority of the Hispanic cases have another risk factor, i.e., homosexual or IV drug use.

Kaposi's sarcoma was observed for many years in Africa and accounts for up to 10% of all malignant tumors in Zaire and Uganda.[52] However, AIDS with opportunistic infection is apparently increasing in central Africa especially Zaire. Both men and women are affected and none have a history of homosexual activity or intravenous drug use.[53,54] Environmental factors may contribute to the epidemiology of AIDS in the tropics.

Screening and prevention • AIDS is presumably a spectrum of disease that ranges from a "carrier state" with minimal or no symptoms to an "AIDS-like illness" with mild to moderate symptoms to the fully developed disease with Kaposi's sarcoma and/or opportunistic infection. Homosexual men with multiple risk factors yet without Kaposi's or opportunistic infection form the highest risk group: so-called "pre-AIDS" or "AIDS-related complex." Prodromal signs and symptoms often observed during the incubation period include fever, sweats, malaise, fatigue, lymphadenopathy, unexplained weight loss greater than 10-15 pounds, chronic diarrhea, leukopenia, lymphopenia, inverted T-cell ratio (T helper/suppressor ratio less than 1.0), and skin test anergy. Preliminary data suggest that AIDS-like illness has a far better prognosis than AIDS.[23]

Diagnosis is made on a clinical basis and there is no specific blood test for early disease. The Tropical Medicine and Traveler's Clinic designed a comprehensive screening program to assess risk factors among homosexual men living in south Florida. The program consists of a detailed history with attention to lifestyle and specific sexual practices and also a physical examination. Screening blood tests include complete count with differential, hepatitis B profile, syphilis serology, sedimentaton rate, urinalysis, skin tests, and stool examination for parasites. "Secondary" screening blood work includes T-cell subset ratio and these results are used to monitor high risk groups over time. Using this approach we identified 12 AIDS patients in 600 individuals and many more in a high risk category.

The program includes a thorough discussion of AIDS with emphasis on modes of transmission. The model of hepatitis B is employed to illustrate how agents enter the blood stream through specific sexual practice. Gay men are counseled to avoid casual sexual contacts, i.e., bath houses, traumatic sexual practices such as fisting (insertion of hand or arm in partner's rectum), anal intercourse (condoms may reduce risk), and to maintain a healthy lifestyle.

Intravenous drug use especially with shared needles is a major risk factor. AIDS among recipients of massive blood transfusion may be curtailed when markers of the disease are identified (e.g., HTLV antibody) for screening blood.

Since AIDS is probably transmitted person-to-person in a manner similar to hepatitis B, hospital personnel should use the same precautions as those for patients with hepatitis B. For routine hospital care this means avoidance of direct contact of skin and mucus membranes with blood, body fluids which contain blood, or tissue from persons with AIDS.[55] No hospital workers in the United States have acquired AIDS due to contact with patients.[56] Failure to find the disease among friends, relatives, and co-workers of patients provides further evidence that casual contact provides little or no risk.

Conclusion • AIDS remains an epidemic in the United States and there has been a recent upsurge in number of new cases. Young people continue to die and the disease has social and economic consequences far beyond the health of victims. Since there is no definitive treatment for the underlying immunologic defect and a vaccine, if effective, will take years to develop, major emphasis should be on early detection and reducing exposure.

AIDS is a complex syndrome and unlikely to be caused by a single infectious agent. Intense clinical, immunologic, and epidemiologic investigations are needed to solve this extraordinary puzzle. We believe much of the data will come from Florida because of the shared ecology and peoples with the Caribbean.

References

1. CDC — Current Trends Acquired Immunodeficiency Syndrome (AIDS) Update — United States, MMWR 32#24:309-311, 1983.
2. Masur, H.; Michelis, M.A.; Wormser, G., et al: Opportunistic Infection in Previously Healthy Women: Initial Manifestation of Community-Acquired Cellular Immunodeficiency, Ann. Int. Med. 97:533-538, 1982.
3. Harris, C.; Small, C.B.; Klein, R.S., et al: Immunodeficiency in Female Sexual Partners of Men with AIDS, N. England J. Med. 308:1181-1184, 1983.
4. Scott, G.B.; Buck, B.E.; Leterman, J.B., et al: Acquired Immunodeficiency Syndrome in Infants, N. England J. Med. 310:76-81, 1984.

5. Rubinstein, A.; Sicklick, M.; Gupta, A, et al: Acquired Immunodeficiency with Reversed T4/T8 Ratios in Infants Born to Promiscuous and Drug-Addicted Mothers, JAMA 249:2350-2356, 1983.
6. Curran, J.W.; Lawrence, D.N.; Jaffe, H., et al: AIDS Associated with Transfusion, N England J. Med. 310(2):69-75, 1984.
7. Witte, J.J. and Sacks, J.J.: Epidemiology of Acquired Immunodeficiency in Florida, Report, 1984.
8. CDC - Acquired Immunodeficiency Syndrome (AIDS): Weekly Surveillance Report — United States, April 30, 1984.
9. DeJarlais, D.C.; Marmor, M. and Thomas, P.: Kaposi's Sarcoma Among Four Different Risk Groups for AIDS, N. England J. Med. (letter) 310:1119, 1984.
10. Groopman, J.E.; Gottlieb, M.S.; Goodman, J., et al: Recombinant Alpha-2 Interferon Therapy for Kaposi's Sarcoma Associated with AIDS, Ann. Int. Med. 100:671-676, 1984.
11. Kroun, S.E.; Real, F.; Cunningham-Rundles, S.; et al: Preliminary Observations on Effect of Recombinant Leukocyte A Interferon in Homosexual Men with Kaposi's Sarcoma, N. England J. Med. 308:1071-1076, 1983.
12. CDC — Kaposi's Sarcoma and *Pneumocystis carinii* Pneumonia Among Homosexual Men — New York City and California, MMWR 30#25:305-308, 1981.
13. Ziegler, J.L.; Drew, W.L.; Miner, R.C., et al: Outbreak of Burkitt's Like Lymphoma in Homosexual Men, Lancet 2:631-633, 1982.
14. Snider, W.D.; Simpson, D.M.; Aronyk, K.E., et al: Primary Lymphoma of Nervous System Associated with AIDS, N. England J. Med. (letter) 308:45, 1983.
15. Rosen, P.P.; Martini, N.; Armstrong, D., et al: *Pneumocystis carinii* Diagnosed by Lung Biopsy, Am. J. Med. 58:794-802, 1975.
16. Mahan, C.T. and Sale, G.E.: Rapid Methenamine Silver Stain for *Pneumocystis* and Fungi, Arch. Pathol. Lab. Med. 102:351-352, 1978.
17. Kovacs, J.A.; Macher, A.M.; Hiemenz, J.W., et al: *Pneumocystis carinii:* Comparison Between Patients with AIDS and Patients with Other Immunodeficiencies, Ann. Int. Med. 100:663-671, 1984.
18. Drugs for Parasitic Infections, Medical Letter 24#601:5-12, (Jan.) 1982.
19. Hughes, W.T.; Kuhn, S.; Chandhary, S., et al: Successful Chemoprophylaxis for *Pneumocystis* Pneumonitis. N. England J. Med. 297:1419-1423, 1977.
20. Moscowitz, L.B.; Kory, P.; Chan, J., et al: Unusual Causes of Death in Haitians Residing in Miami, JAMA 250:1187-1191, 1983.
21. Guinan, M.E.; Thomas, P.A.; Pinsky, P.F., et al: Heterosexual and Homosexual Patients with Acquired Immunodeficiency Syndrome (AIDS), Ann. Int. Med. 100:213-218, 1984.
22. Wong, B.; Gold, J.W.M.; Brown, A.E., et al: Central Nervous System Toxoplasmosis in Homosexual Men and Parental Drug Abusers, Ann. Int. Med. 100:36-42, 1984.
23. Mathur-Wagh, U.; Enlow, R.; Spigland, I., et al: Longitudinal Study of Persistent Generalized Lymphadenopathy in Homosexual Men, Lancet 1(8385):1033-1038, 1984.
24. Chan, J., M.D., Department of Infectious Disease, University of Miami School of Medicine, Miami, personal communication.
25. Current, W.; Reece, N.C.; Ernst, J.V., et al: Human Cryptosporidiosis in Immunocompetent and Immunodeficient Persons, N. England J. Med. 308:1252-1257, 1983.
26. Whiteside, M.E.; May, R.; MacLeod, C.L., et al: Enteric Coccidiosis Among Patients with Acquired Immunodeficiency Syndrome (AIDS), Am. J. Trop. Med. Hyg. (in press), 1984.
27. CDC — Update: Treatment of Cryptosporidiosis in Patients with Acquired Immunodeficiency Syndrome (AIDS), MMWR 33#9:117-119, 1984.
28. Portnoy, D.; Whiteside, M.E. and MacLeod, C.L., Treatment of Cryptosporidiosis with Spiramycin, Ann. Int. Med. 101:202-204, 1984.
29. Fauci, A.S., et al: Acquired Immunodeficiency Syndrome: Epidemiologic, Clinical, Immunologic and Therapeutic Considerations, Ann. Int. Med. 100:92-106, 1984.
30. Dismukes, W.E.; Stamm, A.M.; Graybill, J.R., et al: Treatment of Systemic Mycoses with Ketoconazole: Emphasis on Toxicity and Clinical Response in 52 Patients, Ann. Int. Med. 98:13-20, 1983.
31. Seigal, F.B.; Lopez, C.; Hammer, G.S., et al: Severe Acquired Immunodeficiency in Male Homosexuals Manifested by Chronic Perianal Ulcerative *Herpes simplex* lesions, N. England J. Med. 305:1439-1444, 1981.
32. Corey, L. and Holmes, K.: Genital *Herpes simplex* Virus Infections — Current Concepts in Diagnosis, Treatment and Prevention, Ann. Int. Med. 98:973-983, 1983.
33. Gallo, R.C., et al: Frequent Detection and Isolation of Retroviruses (HTLV-III) from Patients with AIDS and at Risk for AIDS — Science 224:500-503, 1984.
34. Brun-Vezinet, F.; Rouzioux, C.; Barre-Sinoussi, F., et al: Detection IgG Antibodies to Lymphadenopathy-Associated Virus in Patients with AIDS or Lymphadenopathy Syndrome, Lancet #83189:1253-56, 1984.
35. Vilmer, E.; Rouzioux, C.; Vezinet-Brun, F., et al: Isolation of New Lymphotropic Retrovirus from Two Siblings with Haemophilia B, One with AIDS, Lancet 1(8380):753-757, 1984.
36. Masur, H., et al: *Mycobacterium Avium-Intracellulars:* Another Scourge for Individuals with Acquired Immunodeficiency Syndrome (AIDS), JAMA 2418:3013, 1982.
37. Landesman, S. and Vieira, J.: Acquired Immunodeficiency Syndrome: Review, Arch. Int. Med. 143:2307-2309, 1983.
38. Lane, H.C.; Masur, H.; Edgar, L.C., et al: Abnormalities of B-cell Activation and Immunoregulation in Patients with Acquired Immunodeficiency Syndrome (AIDS), N. England J. Med. 309:453-458, 1983.
39. Oleske, J.; Minnefor, A.; Cooper, R., et al: Immune Deficiency Syndrome in Children, JAMA 249:2345-2349, 1983.
40. Joncas, J.H.; Delage, G.; Chad, Z., et al: Acquired (or Congenital) Immunodeficiency Syndrome in Infants Born of Haitian Mothers, N. England J. Med. 308:842, 1983.
41. Ammann, A.J.; Cowan, M.J.; Wara, D.W., et al: Acquired Immunodeficiency in Infant: Possible Transmission by Means of Blood Products. Lancet 1:956-958, 1983.
42. Cowan, M.J.; Hellman, D.; Chudwin, D., et al: Maternal Transmission of Acquired Immunodeficiency Syndrome, Pediat. 73:382-386, 1984.
43. CDC — Update: Acquired Immunodeficiency Syndrome (AIDS) — United States, MMWR 32:688-691, 1984.
44. CDC — Update: Acquired Immunodeficiency Syndrome (AIDS) — United States, MMWR 33:337-339, 1984.
45. Buck, B.; Scott, G.; Valdes-Dapena, M., et al: Kaposi's Sarcoma in Two Infants with Acquired Immunodeficiency Syndrome, J. Pediat. 103:911-913, 1983.
46. Jaffe, H.W.; Keehan, C.; Thomas, P.A., et al: National Case Control Study of Kaposi's Sarcoma and *Pneumocystis carinii* in Homosexual Men, Part 1: Epidemiologic Results, Ann. Int. Med. 99:145-151, 1983.
47. Detels, R., et al: Relationship Between Sexual Practices and T-cell Subsets in Homosexually Active Men, Lancet 2:609-611, 1983.
48. CDC — AIDS Surveillance Report State of Florida — Tallahassee, 1984.
49. Pitchenik, A.; Fischl, M.; Dickinson, G., et al: Opportunistic Infections and Kaposi's Sarcoma Among Haitians: Evidence of New Acquired Immunodeficiency State, Ann. Int. Med. 98:277-284, 1983.
50. Vieira, J.; Frank, E.; Spira, T., et al: Acquired Immune Deficiency Syndrome in Haitians: Opportunistic Infections in Previously Healthy Haitian Immigrants, N. England J. Med. 308:125-129, 1983.
51. Hensley, G., M.D., Department of Pathology, University of Miami School of Medicine, Miami, personal communication
52. McHardy, J.; Williams, E.H.; Geser, A., et al: Endemic Kaposi's Sarcoma: Incidence and Risk Factors in West Nile District of Uganda, Int. J. Cancer 33:203-212, 1984.
53. Clumeck, N.; Mascart-Lemone, F.; deMaubeuge, J., et al: AIDS in Black Africans, Lancet 1:642, 1984.
54. Clumeck, N.; Sonnet, J.; Taelman, H., et al: AIDS in African Patients, N. England J. Med 310:492-496, 1984.
55. CDC — AIDS — Precautions for Clinical and Laboratory Staff. MMWR 31:577-580, 1982.
56. CDC — Evaluation of Acquired Immunodeficiency Syndrome (AIDS) Reported in Health Care Personnel — United States, MMWR 32:358-360, 1983.

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Roche salutes the history of Florida medicine

THE ICE MAN OF APALACHICOLA



Dr. John Gorrie

Medical history is replete with statistics regarding deaths from fever, and before the middle of the 19th century, little could be done to aid the afflicted. Yellow fever, smallpox, typhoid and scarlet fever were scourges that came in epidemics and caused rapid elevation of body temperature from which, all too often, the victim died.

Even for sunstroke patients, lowering body temperature—when attempted at all—was rough and crude treatment consisting of dunking the victim, often fully clothed, into cold water.[1]

Patented invention

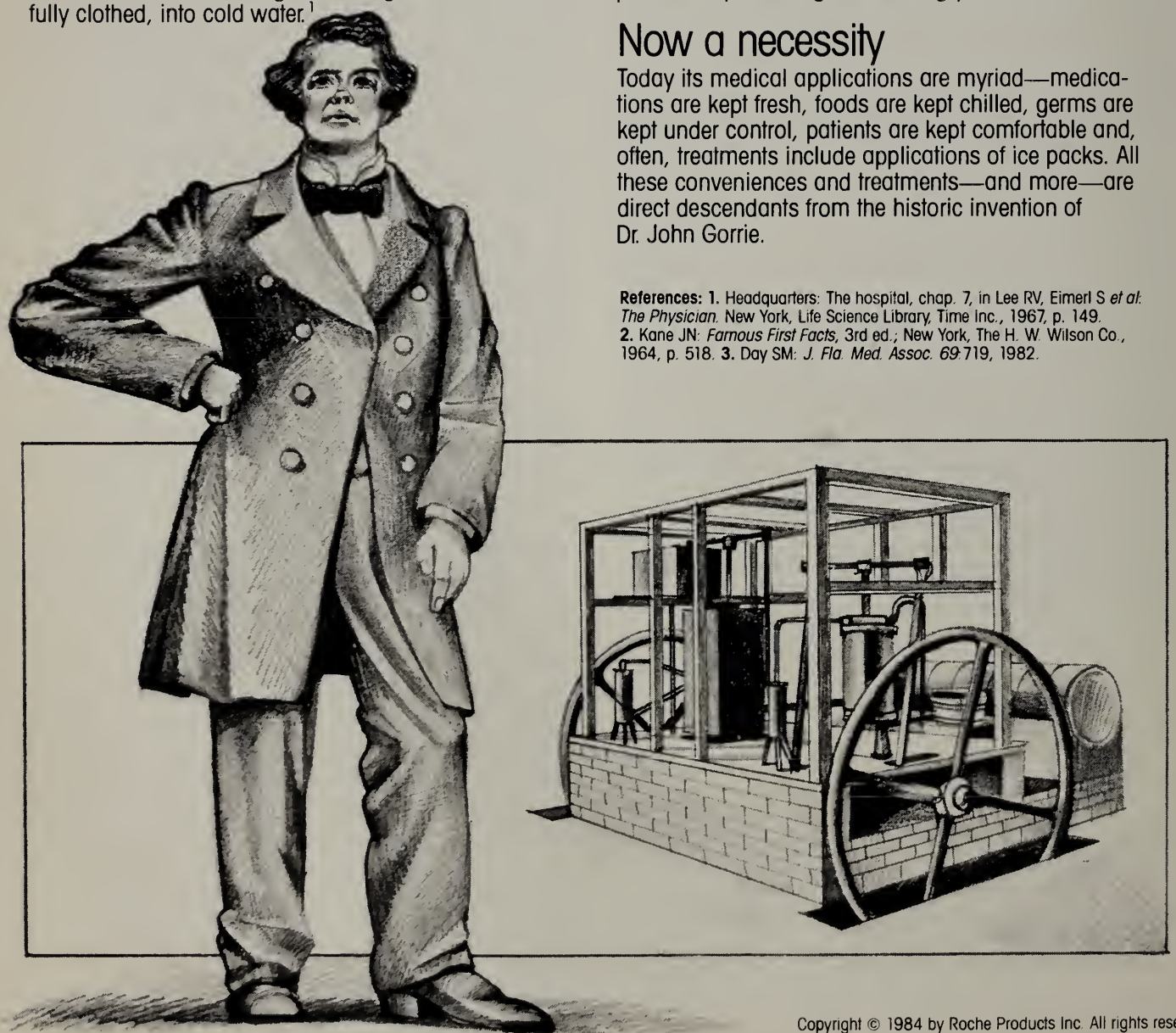
It was, therefore, a significant medical development when, on May 6, 1851, U.S. patent No. 8080 was granted to Dr. John Gorrie of Apalachicola for his mechanical refrigeration technique that perfected the process for making artificial ice.[2]

Dr. Gorrie installed his artificial ice machine in the United States Marine Hospital in Apalachicola;[2] there it came to the attention of other Florida physicians, who began to explore ways of using the ice-making process in preventing and treating yellow fever.[3]

Now a necessity

Today its medical applications are myriad—medications are kept fresh, foods are kept chilled, germs are kept under control, patients are kept comfortable and, often, treatments include applications of ice packs. All these conveniences and treatments—and more—are direct descendants from the historic invention of Dr. John Gorrie.

References: 1. Headquarters: The hospital, chap. 7, in Lee RV, Eimerl S *et al: The Physician.* New York, Life Science Library, Time Inc., 1967, p. 149. **2.** Kane JN: *Famous First Facts,* 3rd ed.; New York, The H. W. Wilson Co., 1964, p. 518. **3.** Day SM: *J. Fla. Med. Assoc. 69*:719, 1982.



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SPECIAL ARTICLE

Maternal deaths in Florida, 1977-1982

A Maternal Mortality Committee report study

Samuel L. Renfroe, M.D., and Dennis Halfhill

The maternal death reveiw has been a part of Florida medicine since 1960. In the 60's and 70's, the Maternal Mortality Review Committee (MMRC) chairman's report was submitted to the Florida Medical Association. Subsequent committee functions were transferred to the Florida Division of Health and later to the Department of Health and Rehabilitative Services (HRS). At the present time this standing committee of the Florida Obstetric and Gynecologic Society annually reports its findings to the Department of Health and Rehabilitative Services. The committee is composed of practicing obstetricians and gynecologists in conjunction with other specialties; i.e., anesthesiology and internal medicine.

The Florida Vital Statistics Section sends a copy of each death certificate indicating a pregnancy-related death to the HRS Health Program Office. This certificate is forwarded to the MMRC chairman who in turn communicates with the attending physician. A copy of the Florida Statutes (Chapter 405.01, 405.02) which explains the physician's exemption from liability for releasing information and the protection of confidentiality of the patient information is forwarded to each physician with the request for information. The patient is given a code number and it is used in all future references to the particular maternal death, thereby maintaining confidentiality when MMRC members review the case.

Data collection has at times been difficult due to the attending physician's reluctance to release the patient's records because of legal liability concerns. The Florida Obstetric and Gynecologic Society and the American College of Obstetricians and Gynecologists are attempting to obtain better physician cooperation by educating the private physicians on the functions of the MMRC and the use of reported information. However, the problem remains a major impediment to reviewing cases meaningfully.

The MMR Committee has believed for many years that a certain percentage of maternal deaths never get reviewed because of the system of reporting. Many patients who die within 90 days of termination of pregnancy may have been treated by physicians in nonobstetric speciality areas. While the death certificate accurately reflects the cause of death, there may be no notation of the preceeding pregnancy. Therefore, review of any possible relationship between the cause of death and pregnancy is lost. One possible help would be to place on the death certificate a check-off box for indicating if the woman was pregnant within 90 days prior to her death. Considerations are currently underway to make this change.

Data collected by the MMRC include office records, hospital charts, autopsy and medical examiner reports. These data are forwarded to a MMRC

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Table 1. — Total Resident Live Births (White and Nonwhite) and Population, Florida 1977-1982.

	Total Live Births			Midyear Population Estimates State of Florida		
	Total Live Births	White	Nonwhite	Total*	White*	Nonwhite*
1977	110,883	80,947	29,890	8,717	7,525	1,193
1978	113,367	82,304	31,033	8,966	7,761	1,206
1979	121,145	88,712	32,403	9,294	8,071	1,223
1980	131,811	96,508	35,284	9,836	8,258	1,578
1981	138,521	101,038	37,450	10,196	8,557	1,639
1982	131,994 (11 mos.)	97,231 (11 mos.)	34,737 (11 mos.)	N/A	N/A	N/A

* Totals omit 000

Table 2. — Maternal Mortality Rate per 10,000 Births Florida 1977-1982.

	1977	1978	1979	1980	1981	1982*
Total Maternal Deaths	2.16	2.12	1.82	1.52	1.16	N/A
Direct Cause	1.81	1.50	1.24	1.37	0.94	N/A
Other Cause	0.36	0.62	0.58	0.15	0.22	N.A

* Population not available.

member for a detailed review. At the meeting of the committee the case is presented, discussed and classified as to (1) cause of death (direct, indirect, unrelated), (2) preventability (yes, no, unknown, not classifiable), (3) responsibility (patient, physician, hospital, midwife, unknown) and (4) diagnosis (hemorrhage, toxemia, infection, vascular accidents, anesthesia and other).

Since there are less than 30 deaths each year, composite reporting is carried out. Table 1 gives state population data including total live births, by race, and midyear total numbers. Table 2 reflects

Table 3. — Classification of Maternal Deaths by Diagnosis, Direct Cause of Death, Florida 1977-1982.

	1977	1978	1979	1980	1981	1982
Total Deaths	24	24	22	20	16	14
Direct (Indirect)	20 (4)	17 (7)	15 (7)	18 (2)	13 (3)	13 (1)
Hemorrhage						
Ectopic pregnancy	3	3	3	4	3	1
Abruptio placentae	—	—	1	—	1	—
Uterine laceration (rupture)	—	2	—	1	—	3
Intracerebral hemorrhage	3	1	2	—	—	—
Incomplete abortion	1	—	—	—	—	—
Placenta accreta	—	—	—	—	—	—
Retained placenta	1	1	—	—	—	—
Uterine hemorrhage (atony)	1	—	—	—	1	—
Toxemia	2	2	2	1	—	—
Infection (septicemia)	3	—	1	3	3	—
Vascular accidents						
Pulmonary thromboemboli	2	3	2	2	1	4
Amniotic fluid emboli	2	1	1	3	1	—
Air emboli	—	—	—	—	1	—
Cerebral thrombosis	—	—	—	—	—	1
DIC	1	—	1	1	—	1
Congestive heart failure	—	1	—	1	—	1
Myocardial infarction	—	1	—	—	—	—
Anesthesia						
Aspiration	1	—	—	—	—	1
Hypoxia	—	1	1	—	—	—
Rupture esophagus	—	—	—	—	—	1
Respiratory						
Adult respiratory syndrome	—	—	—	2	1	—
Pulmonary edema	—	1	—	—	1	—
Cardiopulmonary arrest	—	—	1	—	—	—

Table 4. — Resident Deaths by Race and Age 1977-1982.

	1977	1978	1979	1980	1981	1982
Race	*1		*2	*3	*4	
White	10	10	3	7	4	9
Nonwhite	12	8	10	5	4	5
Age						
Under 20	4	3	1	1	1	—
20 - 34	10	13	9	8	7	12
35 - 44	5	1	2	3	—	2
Over 44	3	1	1	—	—	—

*1 2 cases (age, race unavailable)
*2 5 cases (age, race unavailable)
*3 8 cases (age, race unavailable)
*4 6 cases (age, race unavailable)

the total resident maternal deaths and maternal mortality rate per 10,000 live births by race. Table 3 gives a more detailed breakdown of the maternal deaths by diagnosis. Table 4 addresses the age and race distribution of deaths.

Needless to say there are many kinds of multiple diagnoses possible but an attempt was made to select the predominant cause of death. There were several nonrelated or indirect causes of death such as: sarcoidosis, cardiomyopathy, Reyes syndrome, bronchial pneumonia, drug abuse, automobile injuries, gunshot wounds, arteriovenous malformations, mitral valve prolapse, intracranial aneurysm, suicide and leukemia. One of the more unusual was air embolism from oral-genital acts.

In analysis of the direct causes of death, it was the committee's belief that if the absolute criteria of an ideal hospital setting with an appropriately trained obstetrician/gynecologist were present, many times the physician and/or the hospital's services were responsible for the maternal death. It was the consensus of the members that in approximately 40-50% of the cases, there was a contributing element(s) by the physician, community, hosptial or the patient, i.e., timeliness of reporting symptoms to her physician, physician missing or not managing the case in the appropriate manner or the hospital not having facilities compatible with proper management.

In looking at the six year review of maternal deaths, ectopic pregnancy, infection and pulmonary embolus as well as amniotic fluid embolus are the leading causes of death. The need for early suspicion, diagnosis and treatment of ectopic pregnancy is underscored. A random scattering of other causes can be noted from Table 3. Table 5 reflects the changing mode(s) of delivery of health care, i.e., physician, midwife, and hospital setting.

It is because of these findings that the chairman and the committee feel that there should be intensified efforts toward maternal death review and wider dissemination of that information.

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Table 5. — Total Live Births (Less 19 Years) and Attendance at Delivery.

	Total Resident Live Births*		Attending at Delivery (Percentage)							
			White				Nonwhite			
	White Less 19 yrs.	Nonwhite Less 19 yrs.	MD Hosp.	MD Non-Hosp.	Midwife	Other	MD Hosp.	MD Non-Hosp.	Midwife	Other
1977	8,171 (10.1%)	7,542 (25.2%)	93.6	0.2	2.0	4.2	91.3	0.4	3.5	4.8
1978	8,027 (9.8%)	7,402 (23.9%)	96.1	0.3	2.4	1.2	95.1	0.3	3.6	0.8
1979	7,978 (9.0%)	7,321 (22.6%)	95.5	0.3	3.1	1.1	91.7	0.7	6.5	1.1
1980	8,332 (8.6%)	7,474 (21.2%)	95.5	0.5	3.3	0.9	91.5	0.7	6.6	0.9
1981	8,420 (8.3%)	7,108 (19.0%)	95.3	0.3	3.4	1.0	90.3	0.7	7.6	1.4
1982	N/A	N/A	—	—	—	—	—	—	—	—

* Percentage is reflective of total population delivered that is less 19 years of age.



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NOTES & NEWS

Internationally known immunologist comes to St. Petersburg/Tampa



Dr. Good

Robert A. Good, M.D., world recognized immunologist, researcher, teacher and pediatrician and one of the most cited medical and biological scientists of our time, has joined the staff of All Children's Hospital (in St. Petersburg) and the faculty of the University of South Florida College of Medicine (in Tampa). USF President John Lott Brown announced August 16, 1984, that Dr. Good will carry the titles of University Professor of Pediatrics and Graduate Research Professor. According to J. Dennis Sexton, hospital president, he will be Physician-in-Chief and Chairman of the USF Department of Pediatrics at All Children's Hospital.

Dr. Good will begin his duties with USF/ACH in St. Petersburg January 1, 1985. His program at the hospital will include his research activity and a 10-bed bone-marrow transplantation unit. He brings with him some long-time colleagues, scientists involved in basic immunology research and bone-marrow transplantation. Good will participate in the university teaching programs with both medical students and residents. He will also be involved in patient care.

That Dr. Good's work is the most cited scientific research of our time is a reflection of the enormous impact his discoveries and analyses with respect to immuno-deficiency have had on the developing science of immunology. Dr. Good's studies have helped establish that immuno-deficiency diseases are not rare, as once thought, but a frequent and very important basis of serious disease in mankind (e.g., cancer). Perhaps his most notable contributions have been, in addition to the analysis of immuno-deficiency diseases, the independent discovery of the role of thymus in developmental biology, the recognition and demonstration of the cellular and humoral components as the two basic arms of the immune system, and the discovery of the most useful methods to foster bone-marrow transplantation as an approach to what he has called cellular engineering. He and his colleagues have shown that it is possible to treat and cure children with more than 20 otherwise fatal diseases. Recent progress promises to eliminate the hazards of graft-versus-host disease, a serious obstacle to organ transplantation.

Dr. Good has been the recipient of more than 45 international and national awards, including the prestigious Lasker award, the Gairdner award, the Parke-Davis award in experimental pathology, the Borden award and the Lila Gruber Memorial award for cancer research. He has received honorary doctorates from 10 academic institutions. He is a member of the National Academy of Sciences, a founding member of the National Institute of Medicine, and a member of a National Academy of Arts and Science. He was named the first foreign advisor to the Academy of Medicine in the Peoples Republic of China and advisor to the Peking Cancer Research Institute and Center. He has authored or co-authored more than 1500 publications and has written or edited some 26 books.

Good comes to the Tampa Bay area from the College of Medicine, University of Oklahoma Health Sciences Center, where he was Professor of Pediatrics, Research Professor of Medicine, Professor of Microbiology and Immunology; member and head of the Cancer Research Program, Oklahoma Medical Research Foundation; and head of the section of Pediatric Immunology, Oklahoma Children's Memorial Hospital. Prior to that he was President and Director of the Sloan-Kettering Institute for 10 years and Director of Research at Memorial Hospital in New York.

Indiana University honors Dr. Morgan

Dolores A. Morgan, M.D., was named a recipient of the Indiana University 1984 Distinguished Alumni Service Awards. She and four other IU graduates were honored at a banquet on campus on June 16.

Dr. Morgan is Director of the Addiction Treatment Program of South Miami Hospital. She received her R.N. diploma in 1948, the B.S. in Nursing at

Western Reserve, and the M.A. in Nursing Education at the University of Pittsburgh. After serving as an associate professor and chairman of the Surgical Nursing Department at the Indiana University School of Nursing, she entered the IU School of Medicine, received her M.D. degree in 1968, and then continued with post-graduate training. She served two years as an assistant professor of medicine at the IU School of Medicine before moving to Florida to enter practice, to teach at the University of Miami, and to become director of the Family Health Unit of the South Dade Community Health Center, where she developed a nurse practitioner program for migrant clinic nurses and a model cities health unit. At the South Miami Hospital she is now responsible for administration of its alcohol-drug treatment program components, and she has served as medical director of the Florida Medical Association's statewide impaired physicians program. Dr. Morgan is a Diplomate, American Board of Family Practice, and a member of Sigma Theta Tau, national nursing honorary.

Dr. Collins named to National Certifying Board

Terence R. Collins, M.D., Professor of Community Health and Family Medicine at the University of Florida's College of Medicine, is the new vice chairman of Public Health and Preventive Medicine for the American Board of Preventive Medicine.



Dr. Collins

Elected during the board's summer meeting in Dayton, Ohio, Dr. Collins will fill the office for three years. He will work with other members of the national board in developing the certifying examinations in public health and preventive medicine, and will help select those physicians who are eligible to take the exams.

Dr. Collins is a member of the board's examination committee and is the board's representative to the Residency Review Committee for Preventive Medicine. In addition, he chairs the Graduate Education Committee of the American College of Preventive Medicine.

Dr. Collins also serves as Health Program Supervisor for District III of Florida's Department of Health and Rehabilitative Services (HRS).

DEAN'S MESSAGE

A school of medicine and medical center progress report

The academic calendar of the University of Miami begins on June 1st and ends May 31st. The Medical School has just concluded its 31st year. Recently we submitted this year's status report to the faculty and staff, whose hard work and dedication have enabled us to develop a fine academic Medical Center. This report attempts, in brief, to share some of the progress made in 1983-84. It is divided into the traditional threefold mission of education, research and patient care.

Students • Our School continues to be blessed with the opportunity to train superior students. The Honors Program in Medical Education (B.S. — M.D. Program), in its third year, attracted some of the outstanding scholars in the United States. The original eight students selected for the program entered our School of Medicine and performed superbly well. The forty students in the first and second year on our Coral Gables campus are among the top students in the University's fine College of Arts and Sciences. An excellent group of young men and women entered last fall and it appears that another fine group has been selected for 1984. The students have done well academically, distinguished themselves by their constructive approach to improving the quality of student life, and have made many contributions to community service. The Ph.D. to M.D. Program continues to attract fine candidates and the program was as successful as ever. This year we received more qualified applications for the combined degree (M.D. — Ph.D. Program) than ever before. Recently, we were notified that the Lucille P. Markey Foundation had selected the University of Miami School of Medicine and fourteen other prestigious institutions for support of predoctoral candidates in Physiology and Biophysics, and Pharmacology. Jackson Memorial Hospital and the Veterans Administration Medical Center were extremely successful in the National Intern Resident Match Program. The clinical sections were able to attract some of the best young medical school graduates from all over the nation.

Curriculum • An already strong educational program improved even more during this past year. Our School is most fortunate to have a faculty dedicated to teaching, reduction in the number of didactic

lectures, increased utilization of modern educational technology, emphasis on problem-solving, better integration of the basic and clinical sciences and, most important, the graduation of caring physicians. It is interesting to note that the School's educational goals and objectives developed over the past few years and officially implemented during the past academic year are consistent with most of the conclusions and recommendations to be released this fall by the Project Panel on the General Professional Education of the Physician.

Biomedical research • In 1982-83, an unprecedented number (forty-two percent) of our grants were considered for competitive renewal. The normal percentage of grant renewals is thirty-three. A simultaneous leveling of federal support resulted in a modest decline in total research and training group support from thirty-five to thirty-two million dollars. Fortunately, we were able to attract nearly thirty-five million dollars (exclusive of VAMC research support) during the past academic year. However, the total dollar increase includes a larger percentage of State and industry funds. Thus, even greater emphasis is being placed on competing for federal support. The most recent available data indicates that we were thirty-third among one hundred and twenty-seven medical schools in N.I.H. support during the Federal Government's 1983 Fiscal Year.

During the past several years we recruited three prestigious Basic Science Department Chairmen. Within a short period, the Department of Anatomy and Cell Biology, under the leadership of Dr. Kermit Carraway, Professor and Chairman, has been able to recruit a full complement of fine, young scientist-educators who have interacted extremely well with the entire Medical School's scientific community. The potential of the Department of Pharmacology has never been better. Dr. James D. Potter, our new Chairman, has recruited several new faculty members with impeccable credentials. Within seven months of Dr. J. Wayne Streilein's appointment as Professor and Chairman of the Department of Microbiology and Immunology, six additional faculty members were added. Each of them has outstanding credentials and there is every reason to believe that our School of Medicine has an opportunity to become a major force in the field of Immunobiology. The dual appointment of Dr. David Puett by the Department of Biochemistry and Obstetrics and Gynecology to direct the Reproductive Sciences in the Endocrinology Laboratory Program has already had a major impact on several programs. Although the number and quality of scientists that have been attracted to the School are impressive, the most important aspect of the School's new commitment to fundamental science is the faculty's willingness to work as a team. This has permitted our Medical School to develop shared resources, submit multidisciplinary grants, become substantially more competitive for institutional support and, more importantly, develop meaningful interaction among individuals with diverse scientific backgrounds.

Patient care • This year has been characterized by substantial progress in all clinical areas, especially in the direct provision of patient care. We still need to improve our technical systems and to obtain additional physical resources in order to achieve our goal of becoming one of the finest Medical Centers in the nation.

This past year our clinical faculty has stiffened our professional standards for the provision of clinical care. In many ways, these are more demanding than the federal regulations. The purpose of establishing our own standards was to reaffirm our commitment to quality clinical care, to define our own expectations, and to critically monitor the standards of performance. The creation of professional standards led to the drafting of standards of conduct for all Medical School employees who interact with patients in the Medical Center. Although the new patterns of performance have only recently been implemented, it is noteworthy that patient feedback regarding almost every aspect of clinical care in the Medical Center has been gratifying. The importance of an environment that provides care in a dignified, compassionate manner cannot be underestimated, because only in such a setting can we provide quality education and conduct scholarly clinical research.

Recently, the School and Medical Center received even more recognition for the quality of care when twenty-nine of our faculty were ranked among America's best physicians in *Town and Country Magazine*. Especially noteworthy is the fact that nine members of the Department of Ophthalmology and the Bascom Palmer Eye Institute were singled out for this honor. Because the University of Miami/Jackson Memorial Medical Center has one of this nation's largest commitments to community service, the success of our clinical programs is most important.

I would like to point out just a few of the many improvements made in the facilities and patient-care services at the University of Miami/Jackson Memorial Medical Center during this past year. Possibly one of the most important improvements was in the area of recruitment and retention of the professional nursing staff at Jackson. The hospital initiated a strong CARE program and established the first Center of Excellence. This spring, the East Tower was dedicated and the last of the building associated with the Decade of Progress Bond Issue was completed. Campus beautification continues at an accelerated pace. A new fifteen-hundred-space

parking garage on Tenth Avenue should be completed by October and will be available for us by January '85. The Rehabilitation Unit was cited for excellence in their hospital-based vocational, job evaluation and spinal cord injury programs. All of the hospital's regional programs (i.e., Neonatal, Burn, Transplant, Spinal Injury) continue to be a major resource not only to Dade County but to Florida and the Caribbean. The Bascom Palmer Eye Institute expanded its superb outpatient services and plans for a new Magnetic Resonance Imagining Center. In an era where federal regulations have frequently precipitated serious confrontation between hospital administrators and medical staff, the relationship between the Hospitals and the School has grown even stronger. The same is true of our partnership with the Veterans Administration Medical Center, which remains a national leader in patient service, research and education. Everyone who works in our Center is proud of the relationship that exists between all of the major participants.

We have highlighted some of the progress made during the past academic year. We recognize that the challenges facing the Health Profession and Academic Health Centers, such as ours, are mammoth and on-going. Maintaining the productive momentum achieved over the past years will not be simple. However, we are convinced that our School of Medicine will be able to handle any of the problems that may arise. We are enthusiastic and optimistic because of our deep confidence in the people who have brought our Medical Center to its present state of excellence. We anticipate being able to report even more progress next year.

Bernard J. Fogel, M.D.
Vice President for
Medical Affairs
Dean, School of Medicine
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WORTH REPEATING

Too many lawyers?

The *AMA News* (September 16, 1983) reports that the American Bar Association (ABA) is concerned about the increase in the number of lawyers, having estimated that by the end of 1983 there would be 650,000 lawyers in the United States and by the mid-1990s they will number 1 million. The ABA is worried that this rapid increase in the number of lawyers "may lead to a decline in the image of lawyers and more client complaints if lawyers resort to shortcuts or delay tactics to keep their incomes up, according to *U.S. News and World Report.*" There may be others who worry, or ought to be worrying, about the economic impact of such a dramatic increase in the number of lawyers. A more or less comparable percentage increase in the numbers of doctors in more or less the same time frame has caused considerable public discussion about the effect this increase might have on the costs.

A precise breakdown of costs for either the health care system or for the legal system is difficult to come by. At the moment more attention is being given to the costs of health care. Its total costs have been linked to the gross national product and are now said to be more than 10% of it. But it is hard to believe that the total costs of our legal system are not of a similar order of magnitude (even if one chooses to overlook what seem to many to be unconscionable awards in some liability suits), and it is also hard to believe that a rapidly increasing number of lawyers will not have an economic impact upon the total cost of the legal system to the public.

More attention is needed to these issues. The costs of the legal system are surely as important to Americans as is the cost of health care. But the present social and political climate being what it is, it seems unlikely that the legal system and the legal profession will be asked the same kind of questions about costs as are being asked of the health care system and the medical profession. In the meantime there would seem to be many other good reasons to be as worried about there being too many lawyers as is the ABA.

Malcolm S.M. Watts, M.D.
Editor

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Do we really need more doctors?

And so it came to pass: The Graduate Medical Education National Advisory Committee in 1980 confirmed the earlier prophecy of a physician surplus, announcing that there will be 70,000 more physicians than we need by 1990. If there were skeptics then, there are fewer of them now.

Statistics tell the story better. Community after community across the United States, whether big or small, urban or rural, are reporting an unparalleled number of physicians settling to practice, including specialists and subspecialists. Some places, mainly

in the West and in the Northeast, are already reporting a glut this early. Many young physicians coming out of their training and fellowships are finding it harder and harder to obtain suitable opportunities, most of all the chance to locate in places where they want to. In some big cities, some hospitals have closed their staffs to new applicants and many others are contemplating on doing the same. Even medical schools, for the first time in many years, have reported a drop in their enrollments for 1983. As if to orchestrate the whole scheme of things, Congress as early as 1976 passed Public Law 84-494 which effectively slammed the door shut on many of foreign medical graduates who for many years have comprised ⅓ of the nation's practicing physicians.

Is this good, bad, or does it really make any difference? Perhaps a glimpse into the recent past will supply us the answer.

The government first set the motion for an increase in the physician supply in the 60s by increasing the number of medical schools, allowing these schools to increase enrollments through capitation grants, and liberalizing immigration policies which allowed thousands of physicians from all over the world to come here in an exodus that has been called a brain drain. The early impetus was to redress a long-standing physician shortage, particularly in the rural areas; the later motive was to promote increased competition ostensibly to make medical care less expensive when the costs began spiraling out of sight. While the shortage of physicians is now perceived as largely having been corrected, the hoped-for reduction in the cost of medical care has not materialized despite the increased competition.

On balance, the increased physician supply has made accessible to Americans living even in the most remote hamlets the miracles of modern medicine. Mayo Clinic, Johns Hopkins Hospital, and Massachusetts General Hospital used to be places of pilgrimage for sick Americans, but one need not go nowadays beyond the doors of the local community hospital to obtain the same services and benefits. The increase in doctors also led to the revival of family practice and primary care, making it easier for patients to have access to medical care. Only a few pockets in the nation remain short of medical manpower, and these are mainly in the inner city slums where physicians are reluctant to locate because of the high crime rates.

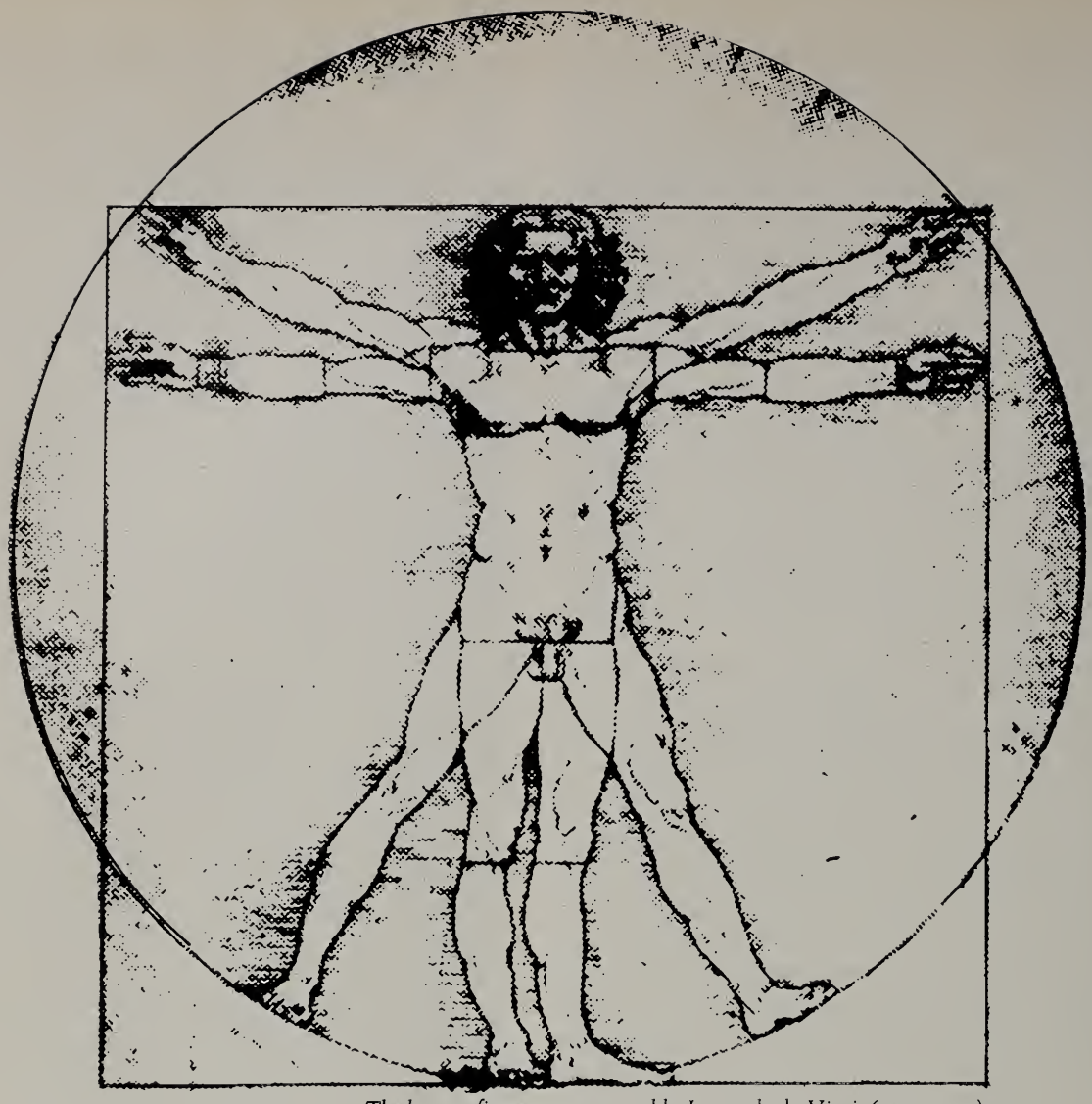
But there are also disturbing things about a physician glut. The anticipated reduction in the cost of medical care, as alluded to earlier, has not come to pass; instead, the government found that each new physician generates between $250,000 to $500,000 of extra costs per year to patients, particularly in the light of new technological advances. Because of this failed policy to cut costs through an increased supply of physicians, the government is now pouncing on the medical profession through an increasing number of onerous regulations that may effectively muzzle physicians in delivering high quality of medical care. Health care is now being rationed in one form or another, discount medicine is being marketed under the banner of increased competition, and health containment may so dominate the thinking of physicians that they may compromise the care of patients.

In addition, the anticipated scramble for patients, which is already happening in many places, has reared its ugly head with the introduction of cheap commercialism into a once noble calling, and it will undoubtedly lead to other pernicious practices which will tarnish the already tainted image of the medical professionl It is a truism that when there is not enough work for everybody, the usual by-products are abuses, hucksterism, and poor, shoddy medical care.

The medical profession and the American Medical Association have been accused in the past of trying to perpetuate a monopoly by limiting the number of medical students. Physicians, critics charged, had a vested interest in keeping their numbers down. In the context of what has been happening, those are preposterous charges. Physicians will concede that they will be earning less, but this is an issue that pales in comparison to all the potential problems that will befall the medical profession. Some of these problems are here, others are on the way. The case is strong at this point to conclude that too many doctors is unhealthy for America.

R.G. Lacsamana, M.D.
Daytona Beach

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The human figure as constructed by Leonardo da Vinci, (1452-1519).

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Book Review Editor — **F. Norman Vickers, M.D.**

Airborne and allergenic pollen of North America

By Walter H. Lewis, Prathibha Vinay, and Vincent E. Zenger, 254 Pages. Price $60.00. Johns Hopkins University Press, Baltimore, 1983.

This book is an indepth treatise on airborne pollen producing plants of North America. It includes excellent color photos for identification of common plants which cause allergeric diseases.

A description of the individual plants includes their botanical distribution, pollen morphology (including electronmicrographs), and information about their allergenicity. There is a specific section devoted to the distribution of the pollen producing species with maps of the indigenous species and hardiness zone descriptions of the species introduced into North America.

The medical discussion is too brief and over simplified. Some of the distribution maps are misleading. Species indicated to exist in the Tampa Bay area are not found there, i.e., Carolina foxtail *(Alpopecurus carolinianus)*, autumn bent *(Agrostis perennans)*, mouse barley *(Hordeum murinum)*, and wild rice *(Zizamia aquatica)*. A major aeroallergen, Bahia grass *(Paspalum notatum)* is not included. The punk tree, *Melaleuca quinquenervia*, is correctly described as having only minor allergenic importance because of its pollination primarily by insects. The Tampa Bay Area is a unique botanical niche and, in general, the plant distribution as described in the text is accurate. There is little information on the allergenicity of many of the pollen producing plants reflecting the need for more research in this area.

This is an excellent text of aerobiology. It is a required addition to the library of any physician practicing allergy and immunology and anyone interested in the field of aerobiology.

Gerald A. Bucholtz, M.D.
Richard F. Lockey, M.D.
Tampa

● Dr. Bucholtz is an Assistant Professor of Medicine, and Dr. Lockey is a Professor of Medicine and Pediatrics, Division of Allergy and Immunology, University of South Florida College of Medicine, Tampa.

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Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

Media day goes national

Statewide Media Day observed last October for the first time in Florida was successful beyond expectations. It created a good image of the Auxiliary and sharpened our awareness of the media. In the words of one managing editor, "I am amazed to learn of the scope of the work of Florida Medical Auxilians and the good they accomplish in the community."

Through a video tape, fact sheets, exhibits, and brochures, the Auxiliary was able to demonstrate that the physician and his family care about the quality of life. This important first step helped establish credibility with the media.

We now have support from the state media with editorial and feature articles, special features in magazines, time offered for radio and television programs, and our health tips used as public service announcements.

Take a bow, FMA-A and FMA! National has seen the wisdom of our Media Day program. In 1986 the AMA-A will observe their first National Media Day. We are thrilled to know that the positive first step taken in Florida will now be a giant movement all over the United States.

This October each Florida Auxiliary will again sponsor Media Day. We are placing emphasis on the one-to-one media contact throughout the year; however for Media Day special invitations are being issued to media representatives for a reception in their honor. Auxiliary projects and activities are being promoted through exhibits, displays, and video tapes. Local medical societies are being urged to participate and to share mailing lists.

Suggested guidelines for 1984-85:

Be on the lookout for ways to publicize our service projects; place special emphasis on programs for older adults; get health information spots on radio and television talk shows; maintain one-to-one media contact throughout the year; be informed on current health issues; study legislative topics; maintain contact with civic groups and improve our image.

Notable news . . . good public relations

Escambia: WSRE-TV featured the Escambia County Medical Society with a live phone-in program on malpractice questions. The Auxiliary was featured by an interview with Cheryl Saiter. **Marion:** *The Ocala Star Banner* covered the Auxiliary's unique seminar on "Midlife Wellness" with an overview of the seminar, and featured articles on midlife health. **Broward:** Press Conference following a symposium with Dr. Rosalyn Yalow, 1977 Nobel Prize winner as featured speaker, and sponsored by the Auxiliary along with their 10th annual "Total Child Symposium", a program to benefit children in the public schools. **Osceola:** WMJK-MAJICA airs Health Tips in Spanish; WFIV Country 1080 airs the same spots in English; *Osceola Sentinel* setting up editorials as the direct result of Media Day; *This Week*, a weekly paper, had a feature article on Media Day followed by items on Auxiliary functions and projects. **Polk:** *Winter Haven News Chief* had a full page article interviewing Priscilla Gerber on the Auxiliary; *Lakeland Ledger* did an article citing Priscilla as an outstanding county leader; WIPC Radio interviewed Isabella Laude and Donna Barringer in Lake Wales about Doctors' Day. **Alachua** has been featured in *North Florida Living* for their project and work with setting up Robb House as a museum and the medical society headquarters. Other counties are also reporting favorable public relations through health service projects which promote the quality of life for all.

Let us strive to improve our image and work together to prove that the practice of medicine is an honorable and respected profession.

Georgia Canakaris (Mrs. John M.)
FMA-A Public Relations Chairman

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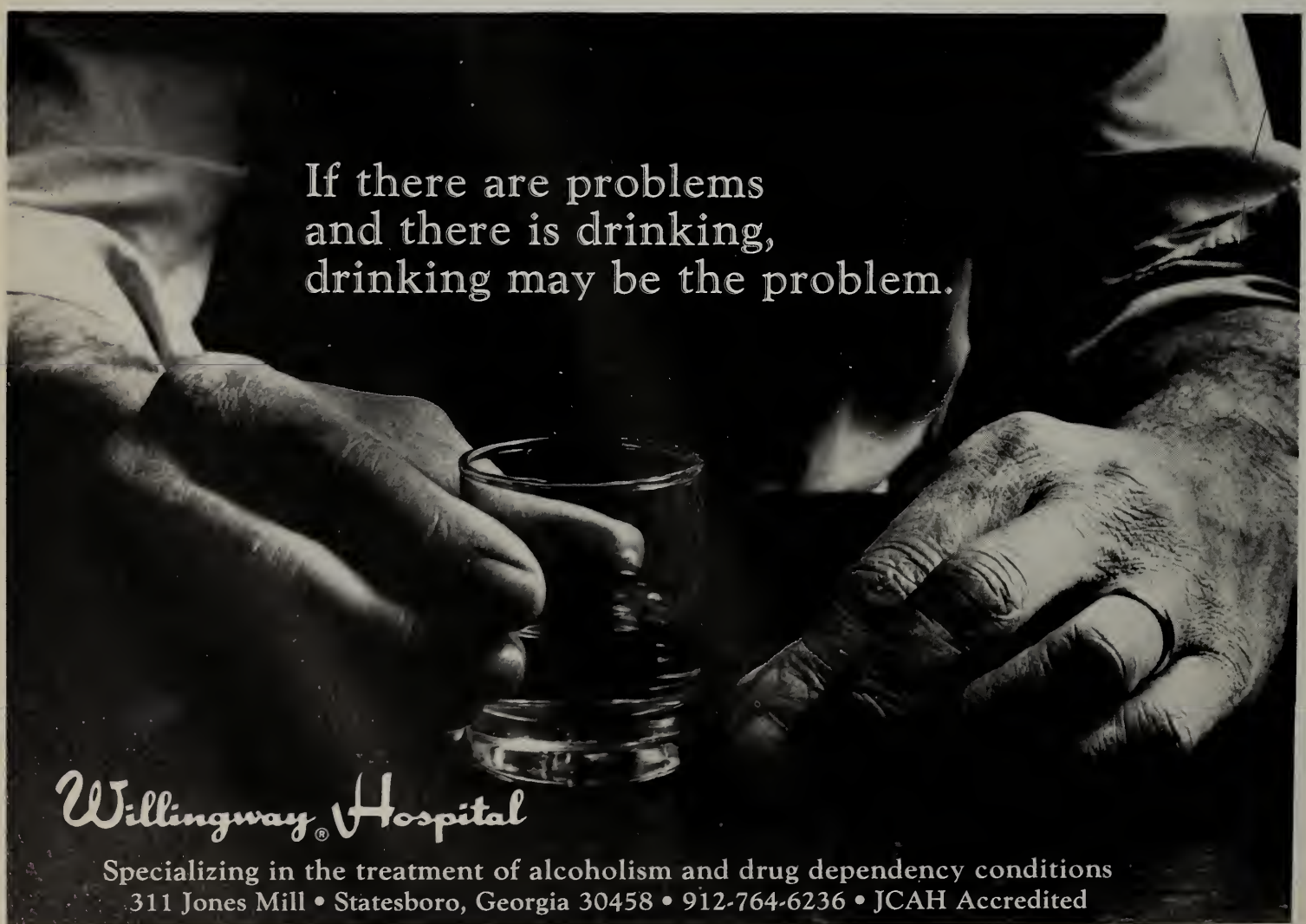
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FMF IMPAIRED PHYSICIANS COMMITTEE NEWSLETTER

Published by the Committee on Impaired Physicians / Florida Medical Foundation / P. O. Box 2411 / Jacksonville, Florida 32203

October 1984 "Doctors Helping Doctors" Vol. 1 — No. 4

Search Is Resumed For Medical Director

The Committee on Impaired Physicians has resumed its search for a full time medical director in the wake of the prime candidate's withdrawal.

"We are naturally disappointed but not defeated," said Guy T. Selander, M.D., of Jacksonville, Chairman of the Committee. "We thought we had our man, but he pulled out on us in the final contract negotiations."

Dr. Selander said the Committee would accept new applications for the position, which requires a Doctor of Medicine degree; a Florida medical license; good health; administrative experience; communications skills; and knowledge and experience in addictionology.

Physicians interested in the position should submit a complete CV and letter of application to: Guy T. Selander, M.D., Chairman, FMA-FMF Impaired Physicians Program, P.O. Box 2411, Jacksonville, FL 32203.

Dolores A. Morgan, M.D., of Miami, has agreed to continue as part-time acting Medical Director until a successor is identified.

DCMA Discontinues Its Impairment Committee

After a review of its committee structure, the Dade County Medical Association has decided to discontinue its Impaired Physicians Committee.

"It was determined that the Association need not continue a permanent committee to respond to the serious problems encountered by our impaired members," a letter from DCMA headquarters advised members. "Rather, it was agreed that the Association should continue to promote educational forums coordinated with our Auxiliary, support the continued efforts of the Impaired Physicians Program, and continue to provide confidential referral into appropriate programs where possible."

The news came as a shock to the FMF Committee on Impaired Physicians, which has been striving toward the ultimate goal of having an impairment committee organized within every FMA county medical society.

"We certainly hope DCMA will give it some more thought and put the committee back on line," Chairman Guy T. Selander, M.D., of the FMF Committee on Impaired Physicians, said. "Dade County's committee was one of the first and one of the most active and effective of our local committees."

'Snitch Laws' Called Deterrents To Success of Recovery Programs

Scores of physicians and interested laymen attended the American Medical Association's 6th National Conference on the Impaired Physician at Secaucus, N.J., last month.

Confidentiality and other legal issues surfaced in one form or another during most of the plenary sessions and discussion groups. Several speakers stressed that confidentiality must be maintained to encourage impaired physicians to enter treatment programs voluntarily. Laws requiring, in some states, the reporting of names of impaired physicians to the licensing boards were viewed as deterrents.

The conference examined California's diversion program and its relationship with the state medical association's program, as well as model programs in place in Georgia and in New Jersey, which has had a full time medical director for about two years.

New York, conferees were told, has raised the physician licensing fee by $10 to provide $350,000 for the Medical Society of New York's rehabilitation program.

Small discussion groups talked about interface between state societies and licensing boards; after-care, monitoring and retraining issues; strategies for acceptance by the medical community and patients; insurance and economic issues; involvement of recovering physicians in state medical society programs, involvement of psychiatrists; involvement of students and residents; working with children and spouses; and leadership issues for medical society executives.

The Florida Medical Association was represented at the September 7-9 meeting by Guy T. Selander, M.D., Jacksonville, Chairman of the Committee on Impaired Physicians; Dolores A. Morgan, M.D., of Miami, Medical Director of the IPP; and Mr. Edward D. Hagan, of Jacksonville, Director of the FMA Department of Medical Services.

Richard J. Feinstein, M.D., of Miami, and James N. Burt, M.D., of Jacksonville, both members of the Impaired Physicians Committee of the Florida Board of Medical Examiners, attended the conference, as did Stanley I. Holzberg, M.D., of Coral Gables, the Board's Impaired Physician Consultant, and Mr. Michael Schwartz of Tallahassee, counsel for the Florida Department of Professional Regulation.

Dr. Morgan Receives Alumni Service Award

Indiana University has presented a Distinguished Alumni Service Award to Dolores A. Morgan, M.D., of Miami, Medical Director of the FMA-FMF Impaired Physicians Program.



Dr. Morgan

Dr. Morgan and four other honored graduates received their citations at a banquet in their honor on campus on June 16.

Dr. Morgan entered the Indiana University Medical School and graduated in 1968 after serving as Associate Professor and Chairman of the Surgical Nursing Department at the IU School of Nursing. She also holds the degrees of B.S. in Nursing from Western Reserve University and M.A. in Nursing Education from the University of Pittsburgh.

IP Committee Changes Rules For Treatment Program Approval

The Committee on Impaired Physicians has amended its criteria for approval of treatment facilities to receive referrals from the IPP.

The rule requiring a facility to have at least a four-year record of treating addiction before it may apply for approval was relaxed to provide for only a two-year record in the case of centers that are affiliated with or are a part of, regional or national concerns that meet the four-year requirement.

Concerned with the wide range of charges made by different treatment centers, the Committee decided to require future applicants to submit their schedules of fees and charges along with their applications. However, the Committee stressed it was not setting any limits or criteria with regard to charges.

Other criteria for approval of treatment centers include: accreditation by the Joint Commission on Accreditation of Hospitals; active medical involvement in the treatment program; affiliation with Alcoholics Anonymous and Narcotics Anonymous; maintenance of a family-oriented care program; and operation of an after-care program.

In another decision, the Committee will conduct site surveys on future applicants.

Dr. Morgan Leaves South Miami; Establishes Program at Mt. Sinai

Dolores A. Morgan, M.D., Medical Director of the FMA-FMF Impaired Physicians Program, moved her base of operations from South Miami Hospital to Mt. Sinai Hospital on Miami Beach, effective October 1.

"We are very excited about this move because we plan to have an exciting educational program and also undertake some research," Dr. Morgan commented. She had been Director of the Addiction Treatment Program at South Miami for the past several years.

Moving to Mt. Sinai with Dr. Morgan were her associates, Jules Trop, M.D., and John C. Eustace, M.D.

At its meeting in Tampa on August 24, the Committee on Impaired Physicians granted temporary approval to the Mt. Sinai treatment program so that IPP patients can be admitted there. The action does not affect the existing approval of the South Miami program.

Dr. Morgan will continue to serve as acting part-time Medical Director of the IPP until a permanent full-time replacement can be found.

Florida Veterinary Group Budgets $6,000 for FMA-FMF Program

The Florida Veterinary Medical Association has allocated $6,000 to the FMA-FMF Impaired Physicians Program for 1985, according to Guy T. Selander, M.D., Chairman of the IP Committee.

Since the IPP began accepting patients almost four years ago, several veterinarians have been processed on referral from FVMA or the Department of Professional Regulation.

"The veterinarians have been our strongest allies and most enthusiastic supporters of our program," Dr. Selander remarked. "We welcome this financial support."

Anclote Manor Opens Unit for Sick Doctors

Anclote Manor Hospital in Tarpon Springs has opened a special psychiatric unit for physicians with emotional and chemical addiction problems.

"Emphasis is placed on involving the physician-patient's family in the treatment process," Anclote's announcement said. "The intensive family therapy concentrates on building a part of the post-discharge support system necessary for recovery.

The unit is directed by Elton L. Hurst, M.D.

FMA Is Co-Sponsor of State Drug Conference

The American and Florida Medical Associations are among sponsors of Florida's first State Conference on Prescription Drug Abuse, to be held in Tampa, October 15-16.

Program planners have sent invitations to 74 organizations, associations and agencies to send representatives to join discussions on prescription misuse, abuse and diversion, as well as related subjects.

The program resulted from discussions within the Florida Prescription Abuse Data Synthesis (PADS) Committee, in which the Florida Medical Association participates, and follows a similar mult-state regional conference at Charleston, S.C., last April.

Program coordinators are Mr. Frank Nelson, of Tallahassee, Director of the State HRS Drug Abuse Program; and Pierre J. Bouis Jr., M.D., Associate Dean for Continuing Medical Education at the University of South Florida in Tampa and Chairman of the FMA Council on Scientific Activities.

Dr. Rogers Is Chairman Of Dependency Section

Arvey I. Rogers, M.D., a Miami gastroenterologist, has been appointed Program Chairman for the FMA Section on Chemical Dependency at the 1985 Annual Meeting of the Florida Medical Association.

The session is planned tentatively for Thursday afternoon, May 2, at the Diplomat Hotel in Hollywood. It will be the fifth consecutive year the Committee on Impaired Physicians has sponsored the section as part of its mission to provide scientific information on chemical addiction to Florida's medical profession.

Dr. Rogers, an experienced organizer of continuing medical education programs, is a member of the FMF Committee on Impaired Physicians and a former member of the Dade County Medical Association's IP Committee.

Dr. Gelfand Is Appointed

Francine L. Gelfand, M.D., of Leesburg, has been appointed Chairman of the Lake County Medical Society's Impaired Physicians Committee.

PRESIDENT'S PAGE

Reason '84 — A reflection



The President's Page provides the opportunity for me to share with you the following text which was prepared to appear in the *Miami Herald* as a "Viewpoint" article in October. It reflects upon the events which led us to the constitutional initiative; presents the true facts about the implications the amendment would have had; and poses important questions about a system gone awry. As you read it, keep in mind that the Supreme Court decision does not signal the end of our labors, but instead should serve to intensify our commitment to resolving this matter.

As President of the Florida Medical Association, I deeply appreciate the *Miami Herald's* offer of space to discuss Amendment 9 and explain why doctors believed that it would help resolve a medical malpractice crisis that has driven up the cost and affected the quality of health care in Florida.

The decision of the Florida Supreme Court on October 3, 1984, removing Amendment 9 from the November General Election Ballot, was extremely disappointing and deeply saddens Florida's House of Medicine; not because the Court's decision was an outrageous travesty of justice — and, in my opinion, it was — but because the ability of the physicians in Florida to deliver quality health care at a reasonable cost to patients was further impaired by the decision.

The proposed REASON '84 constitutional amendment 9, if ratified by Florida voters, would have resulted in a $14 billion savings for the state's health care consumers over the next six years, according to a study by respected Miami economist, M.G. Lewis of M.G. Lewis Econometrics, Inc. Equally important, we believed that Amendment 9 would go a long way toward restoring the trusting relationship between doctors and patients that existed a decade ago before malpractice suits became so rampant. Florida today leads the nation in the average size of jury awards, according to Jury Verdicts Research of Ohio.

Plaintiffs' attorneys, some of whom have become instant millionaires because of these exorbitant awards, deny there is a malpractice crisis. For the benefit of readers, let us examine briefly events of the past decade to demonstrate clearly that a crisis does exist and why FMA was forced to seek tort reform through a citizen-sponsored, constitutional amendment petition campaign.

We think it is no mere coincidence that malpractice suits against doctors began to escalate shortly after the Florida Legislature, in 1971, adopted a no-fault auto insurance law. The law stabilized auto insurance rates by restricting the large number of frivolous lawsuits being filed in the state as a result of auto accidents.

In 1975, the Legislature declared in a resolution that a malpractice crisis existed in Florida because of the sudden, sharp increase in suits against doctors. Premiums soared by as much as 300% in one year, causing major insurance companies to get out of the Florida market and leaving doctors virtually no place to buy liability insurance.

The Legislature responded positively that year with two key remedies. Mediation panels were created to examine the merits of cases filed against doctors, and created a statute permitting Florida physicians to create their own insurance company to provide doctors with protection they could not at that time purchase through commercial carriers.

The mediation panels, whose purpose was to hear all medical malpractice claims and determine if there was evidence of medical negligence, consisted of a doctor and two attorneys, including a circuit court judge.

The panel's findings did not restrict a citizen's right to a jury trial. The findings could, however, be admitted as

evidence in a trial. In 1976, the Florida Supreme Court ruled that the panels were constitutional.

The panels, to the consternation of the trial attorneys, proved to be an effective deterrent to non-meritorious suits. During the nearly five years in which they operated (1976-80), the panels ruled in 93% of the cases that there was no actionable negligence on the part of the doctors being sued.

Significantly, the decisions were unanimous (3-0) in 81% of the cases mediated.

The panels were attacked a second time by plaintiffs' attorneys and again upheld. But on February 28, 1980, with changes in court personnel, the plaintiffs' attorneys' persistent efforts were rewarded when the Supreme Court reversed itself and held that the panels were unconstitutional. The disappearance of mediation panels paved the way for a flood of new cases over the next two years, and 40% more in 1981 than 1980 and 35% in 1980 over 1979. This resulted in an increase in insurance premiums to amounts up to $70,000 annually in the high risk specialties. By 1983, based on Florida Physicians' Insurance Reciprocal records, which insured more than 5,000 of the state's physicians, an average of one out of every four doctors in the state could expect to become involved in a malpractice claim. I doubt that *Herald* readers can think of any other profession that must function in such a threatening environment.

Consumers of health care, our patients, are feeling the effects of this intolerable situation right where it hurts — in their pocketbooks. Obviously, they must pay the higher cost of insurance with higher fees, but just as important, they must pay the cost of "defensive medicine," a practice used more frequently by more doctors these days as a means of self-protection against lawsuits.

Because we face the prospect of being sued if something should go wrong, many doctors order tests and other procedures they might not deem essential. The best estimate is that 30 to 40% of all diagnostic procedures ordered by physicians are attributed to defensive medicine.

In his study of the amount health care consumers could expect to save over a six-year period if Amendment 9 had passed, M.G. Lewis projected a savings of $12.6 billion in six years as a result of the decrease in the practice of defensive medicine.

In addition to being costly to health care consumers, the malpractice crisis has caused a serious deterioration in doctor-patient relationships. Most doctors, particularly the younger ones, are preoccupied with the possibility of being sued.

The ever present threat of a lawsuit affects the physician's practice in several ways. It creates an anxiety in which every patient may be viewed as a potential adversary and in which the physician has begun to picture himself as an inviting target. This dangerous state of affairs not only gives rise to the practice of defensive medicine, but can and does discourage doctors from performing procedures that are worthwhile and proven but also contain a significant degree of risk. For example, a 1983 survey by the Florida Obstetric and Gynecologic Society that same year showed 25% of these doctors had stopped delivering babies and another 30% planned to stop. Again, the chief reason was the high cost of insurance and the threat of lawsuits.

The *Herald's Tropic Magazine* reported this year that Dr. George Pickel, a 46-year-old Miami obstetrician who had delivered more than 5,000 babies, had given up his medical practice to become personnel director for a car rental agency. He made the move after being slapped by two lawsuits which his insurance company settled out of court although Dr. Pickel did not feel he was responsible. He was devastated by the lawsuits, his colleagues reported.

A *Tropic* survey of hospitals in Dade and Broward counties also shows that the birth rate by Cesarean section is almost 50% higher than the national average. It was explained that doctors rarely are sued if they deliver by Cesarean section and the birth is imperfect.

In Clewiston, the local hospital has closed its maternity ward because local doctors have stopped delivering babies. Pregnant women in the area must now drive 60 miles to the nearest hospital delivery room.

In 1983, after a lengthy study by respected members of the medical and legal profession, the insurance industry and members of the Legislature, FMA recommended a legislative package to resolve this crisis on a long-term basis.

Nothing in these recommendations would have restricted a citizen's right to go into the courts to recover damages for malpractice. Never has the Florida Medical Association attempted, in its legislative recommendations or in the Amendment 9 proposal, to remove the responsibility for taking care of a patient who is injured because of the shortcomings of a member of the profession. When accidents occur, they should be recognized and those injured should be compensated to the extent of their need so long as that need exists.

We are deeply concerned that in many cases there is no actual malpractice; nevertheless, the jury, with considerable compassion but without much of an understanding of medicine, will dole out tens and hundreds of thousands of dollars — even millions — to the plaintiff patient. The public will pay this eventually.

The FMA also strongly believes that there is something wrong with a system that frequently gives more money to the attorney than it gives to his injured client. The University Health Trust at Jackson Memorial Hospital in Miami reported that between 60 and 70% of all monies paid out for liability would wind up in the pockets of attorneys under their contingency fee system.

As widely reported in the media, the Legislature rejected in 1983 and again in 1984 the legislative package sponsored by FMA to resolve the crisis. We should say it was rejected by the Florida House, chiefly through the efforts of the House Speaker, a trial attorney, who refused to allow it to come to the floor for debate. The Senate, by contrast, passed the package both years by substantial majorities.

Unable to get the Legislature to act, and after years of exploring ways to solve the malpractice problem, the physicians of Florida and the Florida Medical Association decided to go directly to the people with this issue. The method of amending the State Constitution through petition and a vote of the people, when the Legislature fails to act, was provided for in the 1968 revised Constitution and strengthened in 1972 by an overwhelming vote of the people.

The highest number of Florida citizens in our history — 630,000 — signed petitions to place Amendment 9 on the November 6 ballot.

Florida doctors were likewise committed to pass on any and all of the savings resulting from the effects of Amendment 9 to our patients. This is not a simple commitment, but a solid moral commitment made for a very simple reason — doctors believed that action must be taken to help cut costs and protect the quality of health care.

Passage of Amendment 9 would have accomplished three objectives in civil cases. It would have eliminated the doctrine of joint and several liability which currently puts the defendant at the risk of paying 100% of the damages awarded even though he or she may have had only a minor role in the incident. Secondly, the amendment would have placed a limit of $100,000 on the amount of noneconomic damages, monies awarded for pain and suffering and other intangibles. Thirdly, Amendment 9 would have also required judges to make prompt decisions (summary judgments) in any case where there is no disagreement over the facts of the case.

Nothing in the proposed amendment restricted or limited a citizen's right to sue for malpractice, and nothing prevented a person from recovering all economic losses — loss of wages and earning capacity — and all medical expenses, now and in the future.

Physicians in Southeast Florida have borne the major brunt of this malpractice crisis. They are forced to pay an average of 45% more for professional liability insurance than their colleagues in other areas of the state. South Florida obstetricians and neurosurgeons, two of the most crucially needed specialties, are now paying upwards of $70,000 annually for their insurance.

Plaintiffs' attorneys were particularly critical of the $100,000 limitation on noneconomic damages which would also affect other damage suits. They contended that it would discriminate against low income Floridians.

What these plaintiffs' attorneys were and still are concerned about, of course, is their own pocketbooks. They customarily receive from 35 to 60% of each award as a contingency fee and the pattern of jury awards in recent years has been increasingly large sums for noneconomic damages such as pain and suffering. It is not at all uncommon these days for the plaintiff attorney to make $1 million or more on a single case.

In seeking a limit on these noneconomic awards through Amendment 9, FMA believes that society can no longer afford to enrich people due to exorbitant noneconomic awards which society pays for through increased medical costs. Increasing medical costs are what is hurting low income people the most.

Trial attorneys attempted to mislead Florida citizens through television ads that depicted a drunk driver being "let off the hook" for running over a child. Former Supreme Court Justice Fred Karl, who joined the Reason '84 Campaign as Executive Chairman, said that this was blatantly misleading. Drunk drivers, he pointed out, go to jail, pay fines and penalties and must compensate those they hurt for medical bills and lost wages. In cases of this type of criminal negligence, victims could also collect unlimited punitive damages, Karl said. The $100,000 cap on noneconomic damages would not apply in these cases.

The law firm of Mahoney, Hadlow and Adams of Jacksonville, one of the state's oldest and most respected law firms, agreed with former Justice Karl. Engaged by FMA to research this question, the firm reported there is precedent in law to support Reason '84's position that punitive damages would not have affected tort cases.

The Florida Supreme Court has held that the intent of the framers of an amendment as expressed in public debate is evidence of the public's perception and intent when they vote to approve it. Reason '84 sponsors stressed in its literature and debate that the amendment would not restrict punitive damages. Reason '84 continued to stress this point in debates and advertisements. Our intent was clear and the issue had been adequately explored.

Was Amendment 9 "recklessly tampering" with the Constitution as critics claim? Since the Constitution was revised in 1968, it has been amended 28 times and an additional nine amendments will be on the ballot November 6. Could all of those 28 additional amendments be described as reckless tampering?

Was this the first attempt to limit liability in Florida? No, in 1935 Florida's *Workers' Compensation Law* was passed. It protected workers by allowing them to be adequately compensated for medical expenses and lost wages for on-the-job injuries. But in exchange for this protection, the right of workers to file suit in courts is severely restricted. In 1979, the law was reformed to virtually eliminate attorney fees which were paid on top of awards to injured workers at a cost of millions of dollars annually. In 1971, the Florida Legislature enacted the state's first no-fault auto insurance law due to thousands of damage suits being filed annually that were not only clogging the court system, but driving insurance rates upward to an extent they had become an intolerable burden. The law restricts suits and has saved Floridians millions of dollars in insurance costs.

A key question Florida citizens should ask is this — Would there have been this avalanche of damage suits against doctors if the no-fault auto insurance law had not been approved by the Legislature? Would there be this many suits if attorneys would in some way censure the large number of their colleagues who encourage damage suits through television and newspaper ads? Advertisements that have helped produce a mentality in the population that for every harm, real or imagined, there must be a remedy of money.

The malpractice system that is supposed to protect the public is now being abused and all of the citizens of Florida are paying the price in higher medical bills. The Florida Medical Association embarked on this campaign because Floridians wanted action immediately against the high cost of health care. We were on the ballot because 630,000 registered voters who signed our petition believed we should have a chance to resolve this crisis. Unfortunately, the Supreme Court said no to the citizens of Florida, and again for the second time in 1984, deprived the voters of Florida their basic right to vote on a proposition that was critical to Florida's welfare.

While the Supreme Court's decision is a set back, the Florida Medical Association will continue its fight for tort reform. We will succeed in the long run because reason and justice are on our side.

In an emergency meeting of the FMA Board of Governors held on Wednesday evening, October 3, by telephone, the Board voted to immediately consider future actions for continuing efforts to resolve

this crisis including possible legal actions and further legislative actions, as well as the constitutional initiative process.

Each of you who have participated in this campaign should take pride in your efforts and should not be deterred by this set back in continuing our aggressive and determined efforts to resolve the professional liability crisis in Florida.

Frank C. Coleman MD

EDITORIAL

Physician advertisement — keep it professional

Until July, 1980, the Code of Ethics of the AMA had long stated that a physician "should not solicit patients." It was widely believed that to do so was to demean oneself and his profession. There had been a time in our history when physician advertising was rather widespread. Handbills and brochures touted the superiority of a particular physician and his favorite remedies. As this century began, however, medicine was becoming more of a legitimate science and sought to become a legitimate profession as well. Inherant in the term "profession" are the notions of an orientation toward service to others and of recognition among peers of qualities other than the amount of income made as a measure of success in the field. The direct solicitation of patients was felt to degrade medicine by accentuation of the retail business aspects of the trade.

Leading to the change in the Code of Ethics that saw omission of any reference to solicitation in 1980, was a period of increasing pressure from government agencies to introduce more competition into what they regarded as "the health care industry." That this pressure has been successful can be seen in the degree to which advertising among physicians has again become widespread. In Florida today there are ads for physicians and their offices on billboards, on bumper stickers, in newspapers and playbills, and on radio and television. Apparently there are many among us who are all too willing to behave like an industry.

It has become increasingly obvious that we must develop a greater sense of the ground rules in this new age of advertising. If we are to maintain a sense of professionalism in medicine, the thrust of advertising should be aimed at patient service and at notification of availability, not as self aggrandizement. Medicine should continue to be a field in which success is measured by a practitioner's knowledge, his concern for others, and his willingness to work hard. To seek instant success by mass advertising is to invite a decrease in esteem of the practitioner by his peers and eventually of the profession by our fellow citizens.

Just as medicine is itself based on scientifically demonstrable data, medical advertisement should be limited to objective information. It would be appropriate to advertise such information as special office hours, special handling of insurance or Mediplan claims, or special areas of interest or expertise, for instance. Subjective claims or inferences, on the other hand, are inappropriate. The technique of satisfied client testamonials may be acceptable for detergent advertisements but not for doctors. Such testamonials imply a superiority of a particular physician or group of physicians over their colleagues that can never be objectively proved. Obviously claims of special exclusive knowledge or remedies are out of bounds. We are all familiar with the quacks who claim that their secret cure for arthritis or cancer has been rejected by everyone else in medicine for fear of loss of income. We must avoid such claims even if they are made only by the faintest of innuendoes. We should also avoid playing to the wealth of misinformation believed by many of our patients. The current trends for vitamin misuse and abuse, for fad diets, and for unproven "health maintenance" techniques

should not be supported by the advertisements or practice of legitimate physicians.

Chief Justice Warren Buerger has characterized legal advertising as being like that for dog food, cosmetics, and hair tonic. We cannot let medical advertisement follow such a lead. A doctor's office is not a meat market and should not be advertised like one.

Let us then make a commitment as individuals and as colleagues to keep our advertisement within the bounds of professionalism.

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Ocala



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Childhood cancer care in Florida

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ABSTRACT: Under the auspices of the Florida Association of Pediatric Tumor Programs, a statewide registry has been implemented to monitor incidence and prevalence of cancers in children under 21 years of age. More than 1,300 patients have been registered since its inception in 1980 with approximately 300 newly diagnosed patients registered each year. The incidence among children 14 years of age and younger in Florida is comparable to that reported nationally although distribution by site differs significantly. More than one-third of the cases receive financial support through Children's Medical Services. Thirty-five percent of all cases are registered on national treatment protocols. As additional FAPTP centers have become affiliated with the Pediatric Oncology Group, we expect the percentage of children with access to such protocols to significantly increase within the state. The association has led to great strides in the treatment of childhood cancer within the state.

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In 1970 a coordinated statewide network of Children's Tumor Programs was established under auspices of the Florida Regional Medical Programs (FRMP) with a commitment to improve childhood cancer care in Florida. Subsequently, the FRMP participants incorporated into a nonprofit organization, Florida Association of Pediatric Tumor Programs, Inc. (FAPTP), and the program was extended to include eight participating childhood cancer treatment centers: All Children's Hospital, St. Petersburg (Dr. Jerry Barbosa, Director); Jacksonville Wolfson Children's Hospital (Drs. Albert Wilkinson and Charles Dellinger, Directors); Miami Children's Hospital (Dr. Sergio DeLamerens, Director); Orlando Regional Medical Center (Drs. Vincent Giusti and Kjell Koch, Directors); Sacred Heart Children's Hospital, Pensacola (Dr. Thomas Jenkins, Director); the University of Florida College of Medicine, Gainesville (Dr. Samuel Gross, Director); the University of Miami School of Medicine, (Dr. Stuart Toledano, Director); and the University of South Florida College of Medicine, Tampa (Dr. Janifer Judisch, Director).

Today, this program has achieved state and national recognition for its success in mobilizing a spectrum of resources to achieve its objectives. Key to this accomplishment has been establishment of linkages to all facets of Florida's pediatric oncology care system, including the eight multidisciplinary treatment centers, Comprehensive Cancer Center for the state of Florida (CCCSF), the three medical schools, Department of Health and Rehabilitative Services (HRS), American Cancer Society (ACS), other professional groups such as the Florida Society of Clinical Oncology (FLASCO), Florida Pediatric Society (FPS), Florida Society of Pathologists (FSP), and Florida Radiotherapy Society (FRS), and community physicians. In 1980 establishment and implementation by FAPTP of a comprehensive pediatric cancer regis-

try, Statewide Patient Information Reporting System (SPIRS), marked the development of a distinctive data system for identification and follow-up of all children with cancer treated in Florida. There are few other examples of pediatric registries in existence anywhere in the world[1] that have access to this large a population of comparable size and mix of familial, ethnic, environmental and socioeconomic components within a well-defined geographic area. As such, a regional research laboratory has evolved which assures FAPTP an optimum setting in which to study and promote improved childhood cancer control.

In recognition of this unique capability, the Florida legislature in 1981 established a hematology/oncology program within the Children's Medical Services (CMS) of the Department of Health and Rehabilitative Services and designated FAPTP in this landmark statute as the responsible body for reviewing pediatric cancer data in Florida for preparing annual recommendations to CMS regarding program planning and development.

The present paper describes the operation of this statewide pediatric tumor registry and reviews the data as these describe the patterns of childhood cancer care in Florida.

Statewide Patient Information Reporting System (SPIRS) • FAPTP's statewide pediatric cancer registry provides a vehicle for accomplishing these goals: (1) identifying the incidence and prevalence of childhood cancer cases both in the major pediatric cancer treatment centers and statewide through linkages to other available data bases; (2) monitoring and evaluating pediatric oncology care in the eight centers and ensuring compliance with national standards; (3) providing essential program planning and development information to the centers and the CMS/HRS; (4) monitoring trends in childhood cancer; and (5) conducting research and epidemiologic studies.

SPIRS data consist of three components: new patient registrations, follow-up, and epidemiology. All information is submitted to the FAPTP Central Office and Data Registration Center in Gainesville which is located with the Pediatric Oncology Group (POG) Statistical Center. The Central Office is responsible for data management, processing, analysis, and reporting. Through its interface with the POG Statistical Office, a mechanism is assured for comparing pediatric cancer care in Florida with national and international standards, since approximately 50% of all children treated on research protocols in the United States are followed in POG member institutions.

Patients under 21 years of age presenting in any of the eight FAPTP centers with malignancies or potentially disabling benign tumors,* whether only for diagnosis and consultation or for treatment, are registered in the SPIRS. In almost all instances, this information is forwarded immediately by the pediatric hematology/oncology center director or his staff, as opposed to the usual operational format of hospital tumor registries where the data are based on retrospective abstracts of the medical record. Hence, FAPTP has an exceptional capability to ensure that the data on cases diagnosed in any given year are timely and complete.

Data collected upon registration include demographic, diagnostic and therapeutic. The histologic diagnosis provided on each patient is reviewed and coded individually by a single pediatric pathologist, ensuring uniformity in terminology and coding. The data are manually reviewed by management staff for editing and quality control. All imprecise diagnoses, dates, terminologies, or therapy are noted, and corrections and additions sought. When complete, the forms are keypunched, verified, and entered into the computer. A variety of data quality control checks are completed by computer; coding errors, inconsistent data entries or missing data in items which require an entry, i.e., histologic diagnosis, are corrected by the FAPTP Central Office in conjunction with the treating center.

Follow-up forms are computer generated from the patient registrations and sent to the treatment centers once a year. The follow-up data include information as to where the patient is receiving follow-up treatment, the patient's disease status, treatment experience since diagnosis or last follow-up, the patient's functional ability, the presence and severity of complications and/or toxicities, change in family status, and changes in financial capability.

Epidemiology data are completed on every registered patient at the time of initial registration in the treatment center. The data include demographic information, birth weight, presence of birth defects, parental birth year, medications/treatment and exposures during pregnancy, family history of malignancy, and certain treatment information.

Data linkages and quality control • The FAPTP SPIRS has been designed to permit linkages with other available cancer data bases in the state, thereby permitting: verification of data, and identification of the total population of children's cancers in the state through the addition of those cases not treated in the eight multidisciplinary centers to the SPIRS data. The primary major source of supplementary information for SPIRS is the Florida Cancer Data System (FCDS).

The FCDS is a hospital tumor registry based reporting system for all malignancies required by

law for all Florida hospitals. The data base includes a variety of demographic, diagnostic and therapeutic features in common with the SPIRS data base. By combining SPIRS data with FCDS data, FAPTP can compile a complete population-based data set of all pediatric cancer patients diagnosed and treated in Florida. In addition, the accuracy of commonly reported items is verified through comparison of patient data for those registered in both SPIRS and FCDS or the POG data base since several POG member institutions are in Florida.

Patient accrual • There have been 1,316 patient registrations in the SPIRS since inception of the program in 1980, representing patients diagnosed prior to 1980 (but actually treated in 1980), and 1980 through 1983. The results presented here concentrate on patient care activity in 1980 and 1981.

The number of patients newly diagnosed ranged from 289 to 300 per year (1980-1981) and the number of patients actively receiving treatment in the eight FAPTP centers increased from 360 to 547 for the first two years of SPIRS operation. Figure 1 describes 1981 patients by county of residence. Fifteen percent of newly diagnosed patients are nonresidents of Florida (5% from out of the country and 10% from other states). Among active cases, nonresidents decrease to 12% (4% from out of the country and 8% from other states).

Figure 2 shows where children active in 1981 were referred for treatment. The University of Florida draws the most patients from other states, and the University of Miami and Miami Children's Hospital draw the most from other countries (primarily the Caribbean and South America). Among the Florida resident population, each of the FAPTP centers draws patients primarily from their immediate geographical area, with the exception of the University of Florida which appears to be more statewide rather than regional in its patient referral patterns.

Incidence • The incidence of cancer in 1981 among children 14 years of age and younger in Florida (11.11 per 100,000) is comparable to that reported in the Surveillance, Epidemiology and End Results (SEER) Program (12.09 per 100,000).[2] However, the distribution of these cases (Table 1) by diagnosis is statistically significantly different ($p<.002$) than the distribution found nationally. This difference is primarily due to the lower numbers of cases of brain tumors being reported. The compilation of data for patients diagnosed in 1981 combining SPIRS and FCDS makes it unlikely that these cases are in the population but not reported in either data system.

Results show that childhood cancer rates vary substantially by county, when adjusted for population size, perhaps indicating the role of environmental factors. Analyses of the statistical and clinical significance of the range of variation are in progress.

Children's Medical Services support • The state of Florida is fortunate to have a program to help fund the care of eligible children with cancer. That cancer is also a financially devastating disease needs no amplification. Initially, at diagnosis, the proportion

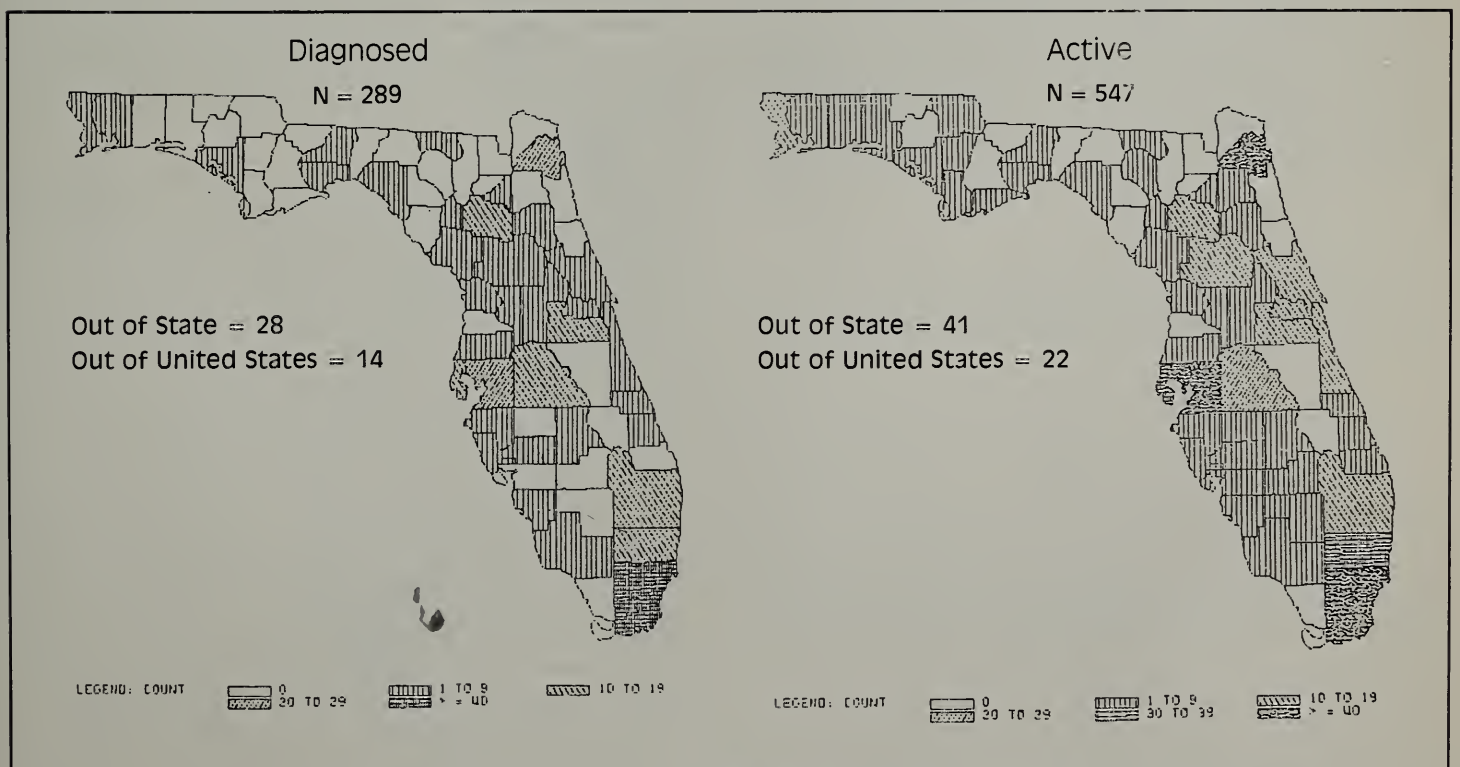


Fig. 1. — Number of patients by county of residence 1981 diagnosed and active patients.

Table 1. — Distribution of Cancer Type in Children Under 15 Years of Age for Patients Diagnosed in 1981.

	Florida (%)	U.S. (%)
Leukemia	35.19	31.03
Hodgkin's Disease	6.48	5.68
Non-Hodgkin's	3.24	6.87
Brain	11.11	17.88
Nervous	1.85	1.93
Eye	4.17	3.40
Genital	2.31	2.89
Bones/Joint	3.24	4.78
Urinary	6.48	6.51
Soft Tissue/Heart	3.24	5.71
Digestive	6.94	3.24
Endocrine	4.17	3.88
Buccal Cavity/Pharynx	2.78	1.12
Miscellaneous and Other	8.80	5.07
Total	100.00	99.99

$p < .0022$

chi square = 32.245

of children partially or fully funded by CMS ranged from 20% to 29% in the years 1980 to 1981. Within two years, the percent of CMS sponsored children among active cases during some time in their treatment course ranged from 35% to 39%. This reflects the increased financial burden of cancer therapy over time.

Pediatric Oncology Group treatment protocols • Table 2 presents the number and percent of patients actively receiving treatment in the eight FAPTP centers in 1981 who were registered on protocols of the Pediatric Oncology Group (POG). Of the total patient population served by the FAPTP centers, 35% are registered on POG treatment protocols; of the CMS population, 50% are registered on POG protocols. Hence, a significant fraction of patients in the state are being followed on protocols and are participating in clinical oncology research. These patients were all registered through the University of South Florida and the University of Florida since they were the only POG members in 1981. The addition of the University of Miami as a POG member in 1982 and the establishment of All Children's Hospital, Jacksonville Wolfson Children's Hospital, Orlando Regional Medical Center and Sacred Heart Children's Hospital as a Community Clinical Oncology Program

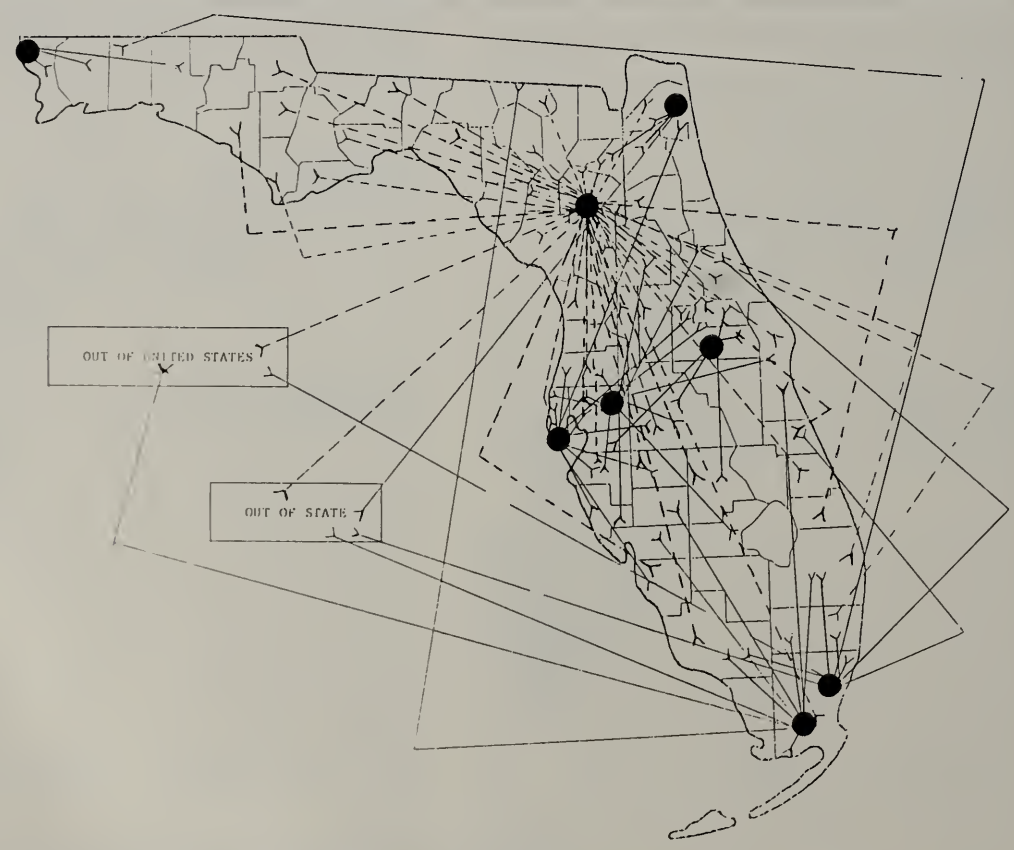


Fig. 2. — Referral patterns of patients active in 1981.

Table 2. — Number/Percent of Patients (active in 1981) Registered on Pediatric Oncology Group (POG) Protocols by Disease Type.

Disease Category	Registered on POG Treatment Protocols (#) % All Patients	(#) % CMS Patients
Leukemia	(76) 40	(43) 55
Non-Hodgkin's Lymphoma	(4) 25	(2) 50
Hodgkin's Disease	(15) 41	(7) 54
Bone/Joint	(26) 51	(6) 43
Brain	(14) 33	(8) 53
Buccal Cavity	(1) 14	(0) 0
Digestive	(6) 25	(1) 25
Endocrine	(5) 26	(3) 75
Eye	(2) 10	(1) 25
Genital	(4) 27	(4) 50
Nervous System	(2) 22	(2) 40
Soft Tissue	(13) 62	(4) 50
Urinary Tract	(12) 40	(7) 58
Miscellaneous Other	(7) 18	(4) 36
Potentially Disabling Benign Tumors	(7) 27	(3) 43
Totals	(194) 35	(95) 50

in affiliation with POG in 1983 will significantly increase these percentages making research protocols available to increasing numbers of Florida's children.

Discussion • Over a relatively short period of time, the Florida Association of Pediatric Tumor Programs has succeeded in uniting the resources of the state into a sophisticated network for ensuring optimum treatment and follow-up of children with cancer. In addition, FAPTP has received a unique legislative mandate to review pediatric oncology data and develop annual reports to HRS for program planning. In order to enhance the training of health professionals in this important subject which leads all other diseases as a cause of death in children, FAPTP, with the assistance of the Florida Division of the American Cancer Society and Children's Medical Services, sponsors an Annual Childhood Cancer Treatment Seminar for nurses, physicians and other health practitioners. In addition, FAPTP has sought to enhance the capabilities of the non-university institutions so that they can also participate in national treatment protocols. The success of these efforts is only now becoming a reality as these institutions, under the FAPTP umbrella, have been approved as a Community Clinical Oncology Program (CCOP) by the National Cancer Institute. This program will increase the availability of POG protocols to children in the state which, in other studies, have shown to have a positive impact on treatment results.[1] The advent of the CCOP will also make available the quality assurance review mechanisms inherent to POG participation as well as provide access to specialized laboratories and investigational drugs.

Preliminary indications of variability in the patterns of childhood cancer in Florida by county which have been discovered by the FAPTP Statewide Patient Information Reporting System bear further analysis. Investigation of possible associations of incidence deviations from national expectations with environmental hazards or adverse pregnancy outcomes is scheduled in the future in an effort to define improved mechanisms for prevention and early detection. Finally, increased participation in national protocol studies promises continued advances in cancer treatment and ensures that Florida's children are receiving the best possible clinical care.

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* Defined consistent with the Surveillance, Epidemiology and End Results (SEER) Program of the National Cancer Institute.

References

1. Meadows, A. T.; Kramer, S.; Hopson, R.; Lustbader, E.; Jarrett, P., and Evans, A. E.: Survival in Childhood Acute Lymphocytic Leukemia: Effect of Protocol and Place of Treatment, Cancer Investigation 1(1):49-55, 1983.
2. Surveillance, Epidemiology, and End Results: Incidence and Mortality Data, 1973-1977; National Cancer Institute, Monograph 57, June 1981, Department of Health and Human Resources, Public Health Service, National Institutes of Health.

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Role of animal laboratories in teaching surgical techniques to gynecology residents

Rex Stubbs Jr., M.D., Robert J. Thompson, M.D., and Guy I. Benrubi, M.D.

ABSTRACT: Two hundred thirty-one program directors of obstetrics and gynecology residencies were surveyed to determine their opinion concerning teaching of surgical technique to housestaff; 73% responded. At the time of the survey 21% of the residency programs were using animal laboratories for teaching. Thirty one percent rotated their residents to other surgical departments. Only 18% believed that residency training should be extended in order to increase exposure to varying surgical techniques.

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During a four year residency in obstetrics and gynecology, the physician receives adequate experience in basic gynecologic surgery. Participation in other procedures such as bowel anastomosis, colostomy and bladder repair is limited by the clinical material available.[1] This has led to concern on the part of program directors that residency training as currently constituted may be inadequate in teaching proper surgical technique. Efforts to remedy this problem have included establishment of animal laboratory, rotation of gynecology residents to other surgical services, and prolongation of the residency training period. In order to determine the opinion of program directors of the efficacy of these alternatives, a survey was carried out.

Materials and methods • Two hundred thirty-one obstetric and gynecology residencies throughout the United States were surveyed. This included all programs having two or more residents per year. Information was requested on the current trends in surgical teaching. The following questionnaire was submitted to the chairman of each obstetric and gynecology program:

1. Is your program currently using a dog laboratory for instruction of surgical techniques?
2. If yes, for how long?
3. If not, do you have plans of utilizing a dog laboratory in the future?
4. Are techniques in repair of bladder and bowel included?
5. Who in your department teaches the procedures learned in the dog laboratory?
6. What level resident is instructed in your dog laboratory?

7. Do residents in your program rotate in other surgical departments?
8. Do residents from other surgical departments rotate in obstetrics and gynecology?
9. Do you feel obstetrics and gynecology residencies should be lengthened for the purpose of improving surgical skills?

Results • There were 169 responses (73%). Of these, 35 (21%) were using animal laboratories for surgical instruction (95% dog model).

The majority of these laboratories (75%) have been available less than five years, 26% have been in operation one year or less. Of the remaining training programs, 22% responded that they plan to initiate use of animal laboratories in the near future.

Techniques of bladder and bowel surgery were most frequently included in the animal laboratory format (84%). Microsurgical technique was also frequently taught.

Oncology attendings were most often delegated the responsibility for teaching these techniques (50%). Gynecology attendings were responsible for 35% of animal laboratories and other surgical attendings in the remaining programs. Third and fourth year residents were most frequently instructed. The remainder of the survey dealt with alternatives for improved surgical teaching other than utilization of animal laboratories. This revealed that only 31% of obstetric and gynecology residencies allow rotations in other surgical departments, many on an elective basis. Even fewer, 24%, offer obstetric and gynecology rotations for surgical residents.

Only 18% agreed with the alternative of prolonging residency training in order to increase exposure to infrequent surgical procedures.

Discussion • The quality of surgical training of obstetric and gynecology residents has been the subject of much debate. In the December 1979 and December 1980 issues of *Contemporary Obstetrics and Gynecology*,[2,3] symposia were conducted which addressed this problem. In the December 1979 issue, a panel of gynecologic oncologists identified obstetrics and gynecology as the only surgical specialty other than ophthalmology which does not require training in general surgery as a prerequisite. The consensus of the panel was that a gynecologic surgeon should be prepared to handle any complication that arises during intraabdominal surgery and two years of general surgery training may be needed for adequate preparation.

In a subsequent symposium, published in December 1980, several directors of obstetric and gynecology programs, none oncologists, addressed the same issue. They agreed that obstetric and gynecology surgical training should prepare the physician to deal appropriately with problems of urologic and gastroenteric systems as well as the reproductive organs. Some participants supported preliminary training in general surgery. Others felt any deficit in training can be alleviated by the nature of the supervision within the current training system.

This survey indicates that lengthening the time of obstetric and gynecology residencies is not well supported by the majority of program directors. Only 18% favored additional time for surgical training. Some responses strongly suggested that programs should be abandoned which have clinical material insufficient for training residents in four years.

The increasing number of animal laboratories planned, and recently implemented, appears to indicate that this complimentary teaching method has an important role in improving surgical skills.

An animal laboratory is provided at the Jacksonville Health Education Program for the teaching of techniques of bowel and urologic surgery to gynecology residents. These include:

I. Bowel Surgery
   - A. Suturing of the intestines with various techniques.
   - B. Cecostomy and colostomy.
   - C. Partial small bowel resection, side to side and end to end anastomosis.
   - D. Construction of ileal conduit to skin and dome of bladder.
   - E. Resection of large bowel and ileocecal anastomosis.

II. Urologic Surgery
   - A. Principles of bladder repair with techniques for reimplantation of ureter.
   - B. Anastomosis of ureter to ileal conduit.

III. Principles of tubal reanastomosis.

All procedures are performed in an operating suite provided by a local veterinarian. The animals used are male and female greyhounds that are scheduled for sacrifice. The cost per animal is $75. Multiple procedures are performed on a single animal prior to sacrifice using standard surgical techniques except that sterile gowns and drapes are not required. This laboratory has been in use for 13 years and all techniques are performed under the guidance of the department chairman. Sessions are conducted weekly, depending on animal availability, with a single postgraduate year three and postgraduate year four resident for two month intervals.

Prohibitive costs of providing this alternative was cited by several directors as a reason for delaying use of the animal model. The director of the University of Missouri's obstetric and gynecology program noted that their animal laboratory intends to utilize pigs as dogs are expensive and difficult to obtain.

The acute model as used by Jacksonville Health Education Program obstetric and gynecology residents allows multiple procedures to be performed and subsequent sacrifice eliminates the costs of extended care. However, killing the animal precludes the advantages of postoperative evaluation and many compromise the total learning experience by making good surgical technique less important. An advantage of the chronic dog model is that the procedures must be performed in an environment in which good surgical technique is required. The major disadvantage of the chronic model is its cost. The choice of acute versus chronic animal model has become a matter of financial and clinical compromise. In Jacksonville as in other communities, an additional factor is the rising public sentiment against using animals for teaching or experimental purposes.

The alternative of rotating obstetric and gynecology residents to other surgical departments allows for a significant exchange of techniques and skills. However, this survey revealed that only a small percentage of programs nationwide participate.

This survey demonstrates that program directors of many obstetric and gynecology residencies are concerned about the surgical experiences of their residents. It also shows that the alternative of animal laboratories for improvement of this experience appears to be favored over lengthening the training period or rotation to other departments.

References

1. Woods, J. R.; Arshacher, R.; Castro, R. J.; Marshal, W., and Trakal, J.: Animal Surgery: Adjunct to Training in Obstetrics and Gynecology, Obst. Gynec. 56:373, 1980.
2. Lewis, J. L.: Symposium — What's Wrong with OB-GYN Surgical Training? Contemporary Obst. Gynec. 14:78, 1979.
3. Lewis, J. L.: Symposium — Problems with Training OB-GYN Surgeons and How to Solve Them, Contemporary Obst. Gynec. 16:136, 1980.

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Recurrent cancer in and about the ear requiring major resection and reconstruction

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ABSTRACT: Twenty patients with recurrent cancer in and about the ear were retrospectively reviewed between 1976-1983 from the newer aspect of evaluation with temporal bone tomograms and CAT scanning. Eleven partial temporal bone resections were necessary. There were 18 parotidectomies and 14 radical neck dissections. Ten deaths occurred over a five-year follow-up period, five within the first year following temporal bone resection. Deaths did not ensue directly from resection. There were no major complications. Two patients have NED at 24-36 months and another four patients have no evidence of disease at 36-48 months, while four are free of disease for 48-60 months. One patient demonstrated metastatic melanoma at five and a half years but is alive and well. While this series is small, we conclude that temporal bone resection offers some degree of palliation and provides cure approximately 50% of the time.

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The management of recurrent cancer in and about the ear requires mature judgment to control the devastating aesthetic and psychologic loss from the resection. The anatomic and physiologic considerations relate to the pinna, hearing and vestibular mechanisms, facial nerve mandible, parotid gland, temporal bone, and lateral neck.[1]

Sophisticated diagnostic methods such as computerized axial tomography and temporal bone tomograms are used to delineate the tumor boundaries and resection in conjunction with neurosurgeons. In reconstruction some provisions must be made for reanimating the ipsilateral face and both the external ear canal and pinna, whenever possible, should be reconstructed for function and appearance.

Method • Twenty cases are reviewed with a predominant pathology of squamous cell carcinoma in 12 patients, basosquamous cell carcinoma in two, basal cell carcinoma in three, melanoma in two, and hemangiopericytoma in one.

The temporal bone resections were either partial or subtotal modifications after the classification of Gacek.[2] All patients had undergone either previous resections and/or had recurrences following radiation therapy.

All patients underwent wide resections of the recurrent cancer. Eighteen patients also had parotidectomies, while 14 radical neck resections were performed.[3] In three patients it was impossible to ablate the tumor because of deep and wide involvement. When the tumor had not penetrated the middle ear structures or the tympanic membrane, a ring of the bony canal was left intact either for immediate or delayed reconstruction of the external auditory canal.

The facial nerve was preserved whenever possible. Six patients had partial nerve resections while in ten patients the nerves were salvaged and one patient had a tumor totally wrapped about the nerve, requiring complete resection. Fourteen partial pareses were incurred. One patient received a nerve graft and two had reanimation procedures. Fourteen received either preoperative or postoperative radiation therapy.

Reconstruction consisted of five split thickness skin grafts, five local flaps, four regional flaps consisting of three pectoralis major myocutaneous and one deltopectoral flap, and two free flaps. One patient did not need reconstruction.

Reconstruction utilizing adjacent or distant flaps was carried out at the time of resection and greatly reduced postoperative morbidity. Adjacent flaps were primarily used in the past and, aside from some scalp distortion, they worked well. Unique hair styles, however, evolved after regrowth of hair from the scalp flap in its new location. Distant island or free flaps have been utilized more recently but they do not match the adjacent skin as well in texture or color as does the scalp flap. They can be used, however, in subsequent reconstruction of an external ear canal and a pinna.

Complications • The complications in our 20 patients consisted of hematoma in three, flap loss in one with a local pericranial flap, infection in two, hearing dysfunction in two, vertigo in one, and knee effusion in another who had a free tensor fascia lata flap.

Discussion • Recurrent tumors of the ear after various treatment modalities have been reported as high as 25% by Blake.[4] There is no doubt that the more advanced, neglected lesions invading cartilage or bone are more difficult to control by any means and a diagnosis of chondronecrosis should be viewed with suspicion since the more likely diagnosis is recurrent cancer. Lesions in the concha and external auditory canal are more difficult to control and have vague borders; surgical resection with postoperative radiation therapy may be advantageous in these infiltrative, ulcerated lesions. The treatment for cancer of the external auditory canal and middle ear produces about a 50% cure from surgery and approximate 33% cure from irradiation alone, according to Million and Cassisi.[5] Blake recommended mono-block clearance of these extensive lesions by a radical mastoid, external ear canal, temporal bone, and neck dissection with parotidectomy if lymph nodes are involved.

Shiffman[6] reported a 19.2% (10 of 52) failure of control of disease in patients with squamous cell carcinoma of the pinna. Four of the patients had radical resection of the external auditory canal and mastoid for primary tumors in that area.

Chen[7] demonstrated an 11% lymph node metastasis in a series of 41 patients who had radical resection of the external auditory canal and mastoid for primary tumors of that area.

Ward[8] also made the point in reporting on five cases that there was a high incidence of metastases in carcinoma of the ear canal.

Hanna[9] carried out radical neck dissections in five out of 12 patients and did modified resections of the temporal bone. Five patients were living free of tumor five years after surgery for a survival of 42%.

Lewis[10,12] reported on radical surgery of malignant tumors of the ear in his classic articles with an overall five-year cure rate of 27%.

Gacek preferred to classify the operations as partial temporal bone resections that sacrificed the outer cortex of the mastoid bone, the cartilaginous segment of the external ear canal and a small portion of the bony canal. He has ten out of 11 five-year survivals in this group. In his subtotal temporal bone resection, the internal auditory canal and labyrinth were sacrificed along with the structures ablated in the partial temporal bone resection for a 25% five-year cure rate. His past category of total temporal bone resection included the petrous apex, but he believed little cure was accomplished by resecting this radically.

Conclusion • During the period 1976-1983, 20 cases of recurrent cancer in and about the ear requiring major resection were reviewed. The death rate was 50% (ten cases of 20) and six of the patients who died had temporal bone resection. Four of the patients died of persistent disease and two of other causes within the first year. Two survived 18 months and two for two years.

Two patients have no evidence of disease at 24-36 months while four are NED for as long as 36-48 months. Four patients are alive beyond five years, but in one metastatic melanoma has developed at five and a half years.

Recurrent cancer in and about the ear is recognized as a very aggressive disease and demands aggressive therapy. In the past temporal bone resection was considered a formidable, almost forbidding procedure. With the aid of temporal bone tomography and CAT scanning, the tumor can be reasonably delineated and the resection thoughtfully planned with neurosurgeons. In our series we had no mortality from the temporal bone resection itself, neither did we incur any major complication secondary to the resection.

We believe that temporal bone resection is a feasible modality and need not have a prohibitive reputation. In our series vital structures were either preserved or reconstructed and from the rehabilitative standpoint, these patients did fairly well.

References

1. Conley, J. J.: Surgical Treatment of Malignant Tumors of Ear and Temporal Cone, Arch. Otolaryn. 47:635-652.
2. Gacek, R. R.: Management of Temporal Bone Carcinoma, Tran. PA Acad. Ophth. Otolaryn. 32(1):67-71 (Spring), 1979.
3. Nordgren, H.: Guidelines for Prophylactic Radical Lymph Node Dissection in Cases of Carcinoma of External Ear, Head and Neck Surg. 2:361-365, May/June, 1980.
4. Blake, G. B.: Malignant Tumors of Ear and Their Treatment, Brit. J. Plast. Surg. 27:67, 1974.
5. Million, R. R. and Cassisi, N. J.: Management of Head and Neck Cancer. Multidisciplinary Approach, Ch. 26, Carcinoma of the Skin, Philadelphia, J. B. Lippincott, 1984.
6. Shiffman, N. J.: Squamous Cell Carcinoma of Skin of Pinna, Canad. Surg. 18:279, 1975.
7. Chen, K. T. K.: Primary Tumors of External and Middle Ear, Arch. Otolaryn. 104:247, 1978.
8. Ward, G. E.: Radical Operation for Carcinoma of External Auditory Canal and Middle Ear, Amer. J. Surg. 82:169-178, 1951.
9. Hanna, D. C.: Suggested technic for resection of Temporal Bone, Amer. J. Surg. 114:553-558, 1967.
10. Lewis, J. S.: Radical Surgery for Malignant Tumors of Ear, Arch. Otolaryn. 83:113, 1966.
11. Lewis, J. S.: Squamous Carcinoma of Ear, Arch. Otolaryn. 97:41, 1970.
12. Lewis, J. S.: Temporal Bone Resection, Arch. Otolaryn. 101:23, 1975.

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Lumbar disc disease: its diagnosis by noninvasive evoked potential recording

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ABSTRACT: This report describes a new, noninvasive method of testing L5 and S1 dermatomal level stimulation and the cerebral recording of these evoked potentials in patients with lumbar disc disease.[1,2]

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Thirty patients, age 30-60, male and female, had signs and symptoms suggestive of herniated lumbar disc disease and were initially treated conservatively. All were subjected to a full battery of neurophysiologic evaluations including needle electromyography, late responses (H reflex and F times) and nerve conduction studies. Patients had initial x-rays of the lumbosacral spines and many had CT scans as well. All were initially given benefit of a period of ten days of conservative therapy.

Patients included in our study group were those who failed to improve with conservative therapy and were, therefore, subsequently subjected to axial myelography with Pantopaque. Prior to myelography, they underwent the noninvasive L5 and S1 dermatomally stimulated somatosensory cerebrally recorded evoked potential (SER-D) study.

The recordings were carried out over the cerebral area thought to account for reception of distally stimulated dermatomal pathways from the lower extremities.[3] The active electrode was Pz with the reference electrode placed 3 cm anteriorly to the midline to Cz. We used the international 10-20% system of electrode placement. The ground electrode was placed halfway between the active and reference recording electrodes. Silver-silverchloride electrodes were used in all cases.

Peripheral dermatomal stimulation was carried out individually on each foot. The first web space between the great toe and second toe was used as the L5 dermatome stimulus point. Cathode was placed at the base of the web space and the annode 2 cm more proximally utilizing an embedded plastic block electrode stimulating device. The S1 stimulus point

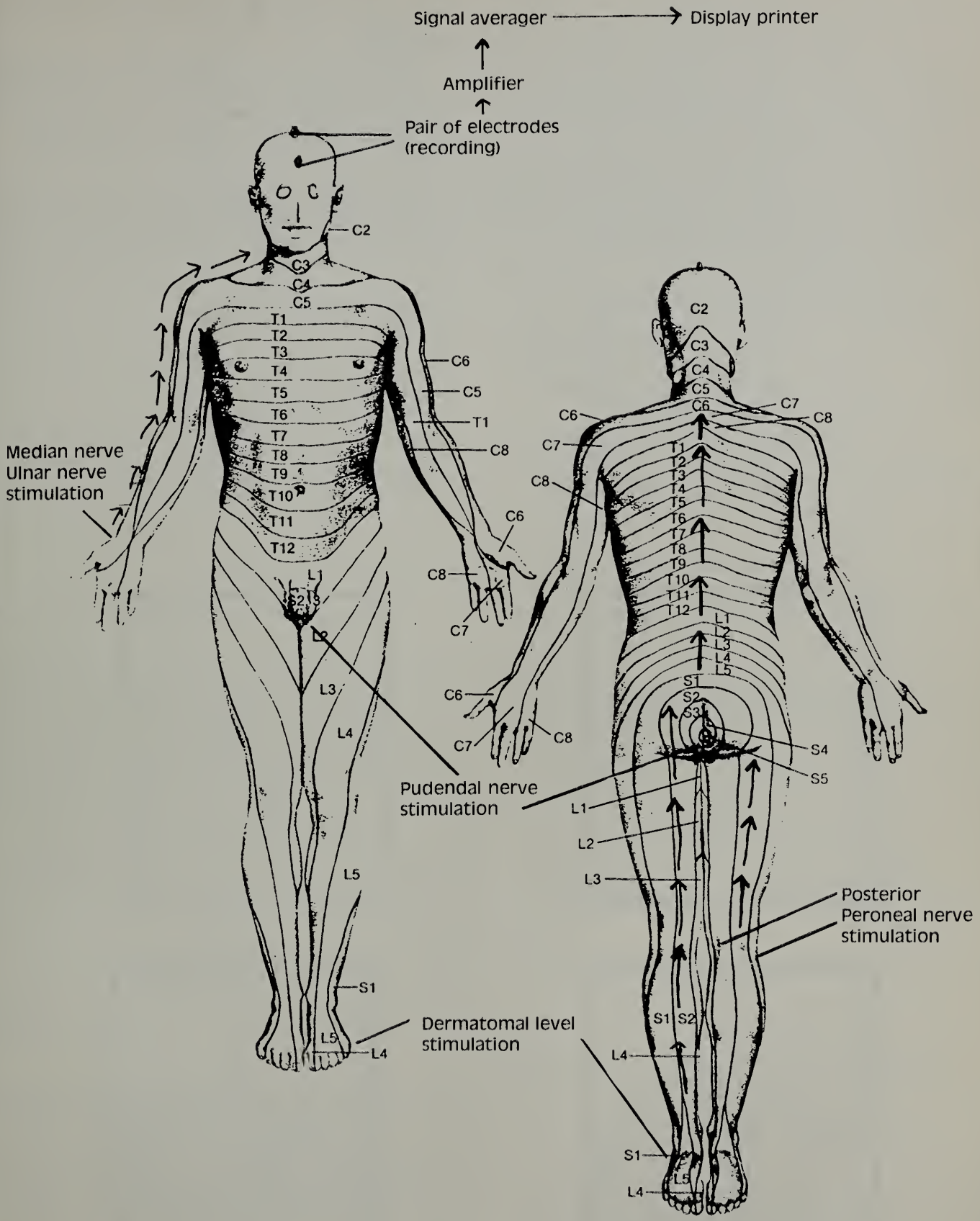


Fig. 1. — Schema of impulses used for somatosensory evoked potentials.

was on the lateral surface (plantar) of the foot 2 cm from the base of the 5th toe. Cerebral sampling was carried out with the peripheral stimuli as previously reported by Scarff,[4] Zenkov[5] and Green et al.[1] A relatively short interelectrode distance was used to limit volume conduction. The electrical intensity of the peripheral dermatomal stimulus was stabilized at a point ⅓ between just felt sensation and pain for each dermatome studied.

Data were collected on commercially available highly reliable Cadwell 5200 apparatus utilizing high frequency settings, filter settings at 200 Hz and low frequency settings at 1 Hz. Sweep time was 10 msec per division and amplitude for averaging was set at 5 microvolts/millimeter. We averaged at least 200 stimuli four times for each particular dermatome stimulated. The Cadwell 5200 apparatus prints all parameters for each recording. All data were subsequently reviewed by two separate Doctors of Medicine reviewers for standardization.

Our prior study showed the clear reliability of this method in normal persons as compared to those with lumbar disc disease. An abnormal study was one in which there were three statistically significant parameters of five measurements taken for each dermatome stimulated and contrasted against the opposite same level dermatome in a right to left comparison.

Consideration for the fact that L5 should arrive at the cerebral cortex prior to S1 was also used as a possible determining factor of abnormality in the consideration of the L5 data from both sides.

Discussion • In our earlier report we contrasted a group of absolutely normal, asymptomatic, healthy individuals with a group of patients who were clearly symptomatic and had other clinical indications of lumbar disc disease. The entire patient group was subjected to myelography and a statistically significant (90%) number of symptomatic patients showed abnormality of the somatosensory evoked response — dermatomal on the correct side.

Utilization of peripherally evoked cerebrally recorded potential has been well documented in the electrodiagnosis of acoustic neuroma,[6-12] multiple sclerosis,[12] cerebral death, retrobulbar neuritis,

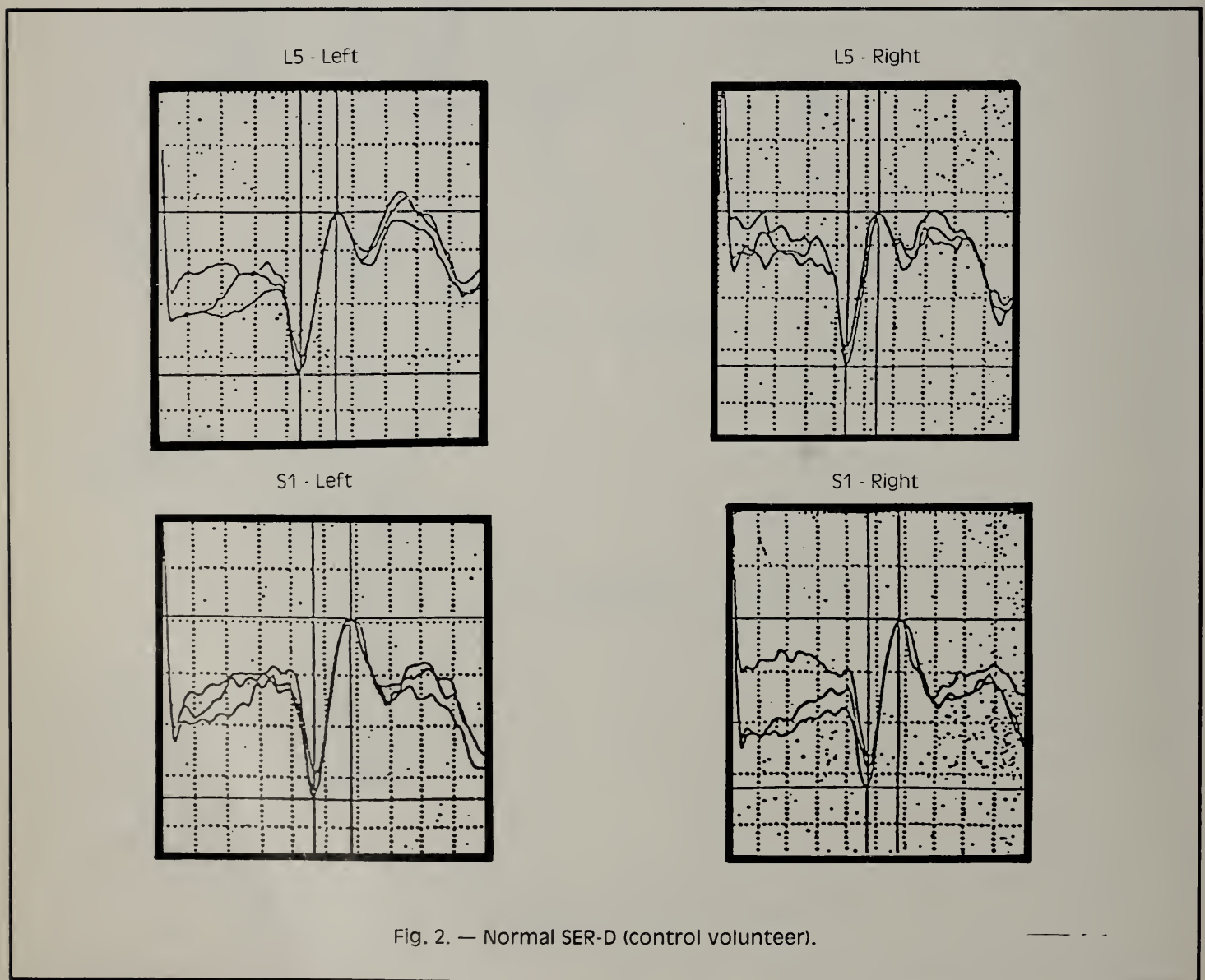


Fig. 2. — Normal SER-D (control volunteer).

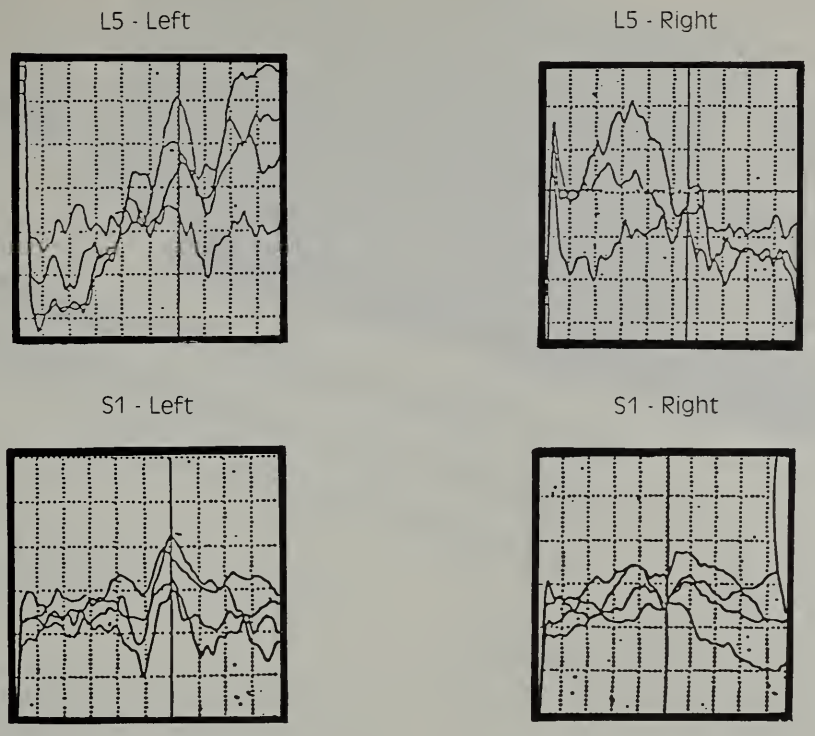


Fig. 3. — Abnormal SER-D; L5 and S1, right S1 maximal involvement.

hysterical blindness and other disease including trigeminal neuralgia.[17-20] Other authors have used evoked potentials as predictive in outcome of head injury patient populations.[21] The utilization of peripherally cerebral evoked potentials for diagnosis of impotence and other genitourinary disorders has also been well established.[22,23]

In this series of patients it appears that the somatosensory evoked response — dermatomal (SER-D) data correlate with the finding of an abnormal myelogram in approximately 90%. This suggests that the (SER-D) study may be performed prior to contemplated myelography in order to better predict who may and may not have positive myelograms, a procedure not without some degree of risk and discomfort.

Summary and conclusions • Somatosensory evoked responses on a dermatomal level appear to be an accurate and noninvasive method of detection of lumbar nerve root impingement. There appears to be some value in performing this procedure in those who have questionable indication for myelography.

Table 1 — Positive myelogram and positive (abnormal) (appropriate side and level) SERD

Total number of patients in sample	= 30%
% Positive correlation (27 patients out of 30)	= 90%
% Negative correlation (3 patients out of 30)	= 10%
% correlation between clinical symptomatology and affected side on those 27 patients with positive correlation	100%

(References are available from the author upon request).

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SPECIAL ARTICLE

Cost containment

Paul F. Wallace, M.D.

It became apparent some time ago that the thrust of the Florida Medical Association meeting would be toward containment of medical costs. You have been reading about possible ways to legislate cost containment practically without let up since the state legislature opened for 1984 business. You have heard the AMA and our own FMA, not to mention some county societies, call for a voluntary freeze on medical fees. You have been aware of newspaper and television editorials calling for an end to the escalating costs of medical care generally. If your patients are anything like mine, I am sure you have had at least one tell you that he is sick and tired of "supporting you lousy, blankety-blank doctors in ways to which you'd like to become accustomed."

They are right, of course. It certainly is no secret that the cost of medical services, like the cost of everything else, has been running wild. And it is not surprising that we physicians draw most of the critics' fire; we are on the front lines and high-profile, a reality we have to live with.

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At the same time, we are victims of an imperfect society. (Some of you may choose to read that as "a litigious society.") It is an increasingly high-tech society in which we expect everything to go as planned and if not somebody is going to pay. That somebody usually is the fellow with the deepest pockets — in the medical field you and me and the hospitals in which we practice.

If there are not at least a few of you who have suffered the agony of a malpractice suit, I would be greatly surprised. It is not without reason that Florida has become known as the number one state in malpractice awards.

It is not without reason that Florida has become known as the number one state in malpractice awards.

The higher those awards, the greater the incidence of malpractice suits. Our insurors, in effect, assume the "deep pockets" role and up go insurance costs. The higher the premiums, the more defensive we become. We order more tests, laboratory work, consultations, and perhaps, more days of hospital confinement. Often they are not needed except for the record, and, of course, that is expensive.

There is a dimension to the problem almost unique to our state — prevalence of retirees, most living on fixed incomes pegged to an economy long past. At the end of 1982 there were 2,150,000 Floridians receiving monthly social security checks regularly or about one in every five persons. While not all of them depend solely upon social security, their sensitivity to rising medical costs is certainly understandable. That sensitivity has created a fertile climate for HMOs, PPOs

and the various other additions to the medical-service alphabet. Whatever our attitude toward those services, the fact is that more and more patients see them as a possible solution to their cost containment dilemma — impersonal though they may be. Like it or not, we have to accept their challenge.

If we are to deal with cost containment, we need to be specific. With that in mind, I asked each member of the Executive Committee of the Florida Orthopedic Society to submit a brief report on his observation of waste, whether in time, supplies, or methods, in our medical practices. Until we create an awareness of cost containment and use that awareness as an overlay for daily routines, we have to plead guilty as charged to being part of the problem we are complaining about.

Until we create an awareness of cost containment and use that awareness as an overlay for daily routines, we have to plead guilty as charged to being part of the problem we are complaining about.

In my area there are several MDs and chiropractors who order thermograms and Doppler tests on every patient involved in a liability case. The AMA, of course, has issued a statement that there is no good clincial use for thermograms at this time. Those of you who attended the fall meeting heard about sophisticated new material that does show promise; however, with the contact type there is no justification for use. Obviously, not every patient needs a Doppler test.

In our area, far too many CAT scans and, perhaps, myelograms are ordered. Doing a CAT scan or myelogram when physical findings are normal, attempting to find something that might pay off on the patient's liability claim, cannot be tolerated. It is as unforgivable to order hot packs and ultrasound in the office when there has been no attempt at exercising or when such treatments have not been called necessary by either the doctor or qualified physical therapist, particularly when therapy continues for as long as a year.

We know hospitals, I am sure, that cater to the doctor who is a heavy user of facilities; they are ready to provide him a special operating table or special instruments. It is good will and from the hospital's point of view good business. These special items too often are not essential to good medicine and the money spent for them represents a waste little known publicly.

A lesser item is fiberglass casts. Their use is often indicated but using them routinely is unnecessary and unduly expensive. Power staples cost more than other staples and all staples are more expensive than sutures. Are we talking pennies? Maybe, but even pennies have a significant bearing on total medical care costs. These are items used hundreds of times a day all over the state. We all have favorite knee and wrist supports, slings and braces. Their cost varies greatly from company to company and purchasing should be by bid. We might also take a look at portable x-ray units — portable and expensive. Do we need to use them?

Several reports from Executive Committee members called attention to the "dear-old-dad" patient. You know him; he's the patient hospitalized when the family wants a week's vacation and "won't you find some excuse, Doc, to keep dear old dad hospitalized until we get home?" Or the "I need love too" patient, the old girl who takes so readily to all the attention the hospital gives her that she asks to stay on just a few days more. "I don't want to be a burden to my family, doctor."

I suppose we all have a tendency to send patients back to work on Mondays — frequently at the patient's request. He does not want to go back in midweek; that seems innocent enough. Think for a moment how staggering the cost of those extra days can be not to mention the domino economic effects of job absenteeism.

Consider the overuse of some procedures, arthroscopic examinations for example. Not long ago, I saw a 44-year-old police officer, overweight and out of shape, who had to run 100 yards in a mandatory fitness test. Not too surprisingly, he ended up with a painful knee. He went to one of my colleagues who immediately scheduled an arthroscopy. He came to me for a second opinion. I found some fluid, aspirated it, put in some steroid, provided a little physical therapy and a week later he was completely well.

We know doctors who do arthroscopic surgery in their offices or as outpatient or one-day-stay in the hospital. It has been pointed out that chemonucleolysis can be done under local anesthesia very safely and, actually, that all deaths associated with this procedure have occurred under general anesthesia.

Comparing costs to the patient and hospital, he found that some items had been marked up as much as 350%.

Consider the waste possible through consultations. One member calls attention to an orthopedic surgeon who summons an internist — or whoever — to consult on every patient and he notes that there is no incentive not to do this. Acutally, malpractice insurors support the practice with the contention that it is good medicine. The practice has been elevated to an artistic level of creativity in some hospitals. A patient mentions a headache and he is seen by a neurologist. He feels dizzy and an ENT man is sent in; no harm done. They are victimless little crimes, but they are expensive crimes when committed frequently.

Another member cites a more tangible example of waste and one the patient looks upon as equally criminal. He submitted a patient's hospital bill along with the cost to the hospital of the items billed for, including gloves, drapes, gauze, syringes, and so on. Comparing costs to the patient and hospital, he found that some items had been marked up as much as 350%.

I have mentioned types of patients who for some reason want to prolong their hospital stay. More wasteful, and probably more costly, are those prolonged stays for which we ourselves are responsible.

A professor, who advocates the teaching of cost containment in residency programs, suggests that we can reduce many hospital stays by one day. It is a matter of making rounds early enough so the patient's lab work and x-rays can be done and any cast changes made by the discharge hour. Think of the overall reduction in medical costs if every orthopedist in the country eliminated one day of hospitalization each week. The savings in a year's time would be astounding.

What about the patient with the fractured hip who will be going to an extended care facility? Why couldn't we routinely notify the facility's social worker a day or two post-op when we can safely predict the discharge date? Why wait until the patient is ready for discharge and then wait three or more days until a bed can be found?

What about our tendency to admit patients to the hospital two or three days prior to surgery in order to give them proper work-ups? Shouldn't we consider doing most of this on an outpatient basis?

Consider the little old lady with the badly broken wrist or shoulder who lives alone. We will frequently admit her for a few days until arrangements can be made for home care. Think of what could be saved if there were some way of taking care of these patients without admitting them. Doesn't it suggest that the whole area of home care, especially that being paid for by various governmental agencies, needs revamping?

According to reports, well over 50% of the cost of hospital care is for elderly or Medicare patients, for terminal illnesses, really. This, of course, introduces a moral issue, one we and our legislators will be wrestling with for some time. Can we afford to recognize, being totally realistic, that some lives are unsalvageable? I have ordered tests for patients when I knew only a miracle could save them. You have also, no doubt, even when you knew that to prolong life meant prolonging suffering. I am sure that you and I have been accused by some of prolonging life only to boost our bills a little higher.

There always will be patients whose lives become unsalvageable. They present a difficult problem for the physician. Do we prolong life, doing what we can to lessen suffering, or do we recognize that eventually death is the end to all suffering? Are we to be guided by a terminal patient's sometimes expressed desire to let his life run out? Or by a relative's fear of the guilt trip he will undergo if less than maximum effort is exerted to prolong life? It is a problem over which we physicians really have no control. The solution is being left to the lawyers and the legislators who undoubtedly will be guided by public opinion as they perceive it. We should be making our opinions known to the press, courts, legislators, families of patients, and public. There is little doubt in my mind that prolonging the suffering of a terminally ill patient is immoral; so is draining the coffers of the patient's family in an effort to squeeze in, perhaps, just one more day of tortured living.

To be realistic and, yes, crass, it is an aspect of cost containment we must face up to.

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FLORIDA MEDICAL

DEPARTMENTS

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NOTES & NEWS

Major gift from Palm Beach Heart Association will fund new endowed chair in cardiology at UF

The teaching of physicians in areas related to adult heart disease will be greatly expanded at the University of Florida's College of Medicine, thanks to the funding of a new million-dollar Eminent Scholar's Teaching Chair in Adult Cardiology.

Fundraising leaders with the Palm Beach County Chapter of the American Heart Association announced establishment of the chair at a press conference Wednesday, October 3, after presenting UF officials with a gift of $600,000. Most of the funds were received through bequests to the chapter.

The $600,000 donation will be matched with $400,000 from Florida's Eminent Scholars Trust Program to establish an endowment fund that will be managed by the University of Florida Foundation.

"Establishing a teaching chair is a great opportunity for the Palm Beach County Chapter to continue contributing to the advancement of cardiac care," said Joseph B. Shearouse Jr., who chaired the Eminent Scholar Chair Committee and is president of Fidelity Federal Savings Bank.

During the conference at the Palm Beach County Chapter headquarters, AHA chairman John S. Hughes presented the $600,000 donation in the form of a giant-sized check, to Marshall Criser, UF president, and Dr. William Deal, dean of the university's medical college.

Criser, who returned to his home city of West Palm Beach for the event, told chapter officers, "Your generous gift will make an impact on the nation's number one cause of death by strengthening medical education regarding the latest advances in diagnosis, treatment and prevention."

UF Vice President for Health Affairs, Dr. David Challoner, praised the Heart Association fundraisers for selecting a method of giving that will magnify private donations while making a significant contribution to a medical problem that is of enormous scope.

On behalf of the medical college, Dean Deal announced, "A search will begin immediately to recruit one of the world's leading medical educators and clinicians in the specialty of cardiology to enhance all of our instruction regarding cardiovascular diseases."

At the Palm Beach meeting, Hughes and other chapter officers announced an additional $300,000 contribution has been allocated toward establishing a second endowed chair in pediatric cardiology. Once the full $600,000 has been raised to qualify for state matching funds, the new Eminent Scholar's Chair will be named in honor of Dr. Gerold L. Schiebler, a specialist in pediatric cardiology who has chaired UF's Department of Pediatrics for 16 years and has made notable contributions to improving the diagnosis and treatment of heart disease in children.

Serving with Shearouse and Hughes on the AHA Eminent Scholar Chair Committee are: Bill R. Brown; Dr. Istvan Krisko; Dr. Thomas F. Raymond, and Dr. Donald E. Warren.

LIFETIME announces five new series for "Doctors' Sunday"

Five new television series of medical programs have been developed by LIFETIME and will premiere in January, it was announced here today by Dr. Art Ulene, Chairman of LIFETIME's Medical Television Series.

The five new series will be added to LIFETIME's current slate of medical programs and will be scheduled to run on the new "Doctors' Sunday" 24-hour, all-day-Sunday, medical television service just announced by LIFETIME.

Four of the new series are "Specialty Updates." Each of the series within "Specialty Updates" covers timely information for four medical disciplines. The four specialties are: Cardiology; OB/GYN; Rheumatology and Orthopedics; and Internal Medicine, encompassing Infectious Diseases, Endocrinology and Chest Medicine. "Specialty Updates" are half-hour programs.

The fifth new series for LIFETIME's "Doctors' Sunday" is "Convention Highlights." This one-hour program reports on specialty medical meetings. Such national meetings as American Heart Association would be covered, with segments on presentations of papers by researchers, key speakers, panel discussions and tours of scientific and commercial exhibits.

The five new medical series join LIFETIME's other programs that are produced specifically for physicians and health care professionals. LIFETIME's professional programming now includes "Physicians' Journal Update," "Medical Economics," "Med-Video Clinic" and the series of specials, "Video Seminars." LIFETIME also produces "INFORMATHONS," periodic multi-hour, live, telephone-interactive television specials for physicians and laymen. Each "INFORMATHON" focuses on one health issue of national importance.

Discussing the new medical series that will debut on "Doctors' Sunday," Dr. Ulene said, "Just as LIFETIME serves defined audiences within the overall television viewership, our new medical specialty programs offer physicians timely, vital information they do not get in more general medical programs and journals. We expect our specialty programming to be a valuable resource to teaching hospitals as well as to doctors who cannot travel for educational meetings and conferences."

CPR-Are we training the right people?

While mortality rates attributed to coronary heart disease have declined since the mid-1960s, heart attacks continue to be the major cause of death and disability in the United States, causing 300,000 deaths annually.

The majority of heart attack deaths are sudden, unexpected, and occur outside the hospital. According to an article appearing in the September issue of *Annals of Emergency Medicine*, the most effective treatment of sudden death is bystander-initiated cardiopulmonary resuscitation (CPR). *Annals* is the monthly clinical journal published by the American College of Emergency Physicians (ACEP).

The article reports that up to 12 million Americans have been trained in CPR using the American Heart Association standards, with an additional 50 to 60 million expressing interest in undertaking such training.

"While these efforts are extremely important, limited resources might be more effectively directed at those people most likely to use such skills," says Robert J. Goldberg, Ph.D., author of the study. "It is important for the family members of patients with known coronary heart disease or survivors of heart attacks to be trained in CPR. It also seems likely that these individuals would be motivated to learn the basic life support skills."

Dr. Goldberg and his colleagues conducted the study to examine the extent of CPR training among family members of patients with coronary heart disease, family members of patients without coronary heart disease and a random neighborhood control group.

Results of the study indicate that family members of patients with coronary heart disease were significantly older than were family members in the two comparison groups, and fewer of these family members had taken CPR than the remainder of the population studied.

In addition, there were significant differences in the timing of previous CPR courses. Only 9% of family members of patients with coronary heart disease had taken a CPR course within the past three years, while a total of 34% of the other groups had. Furthermore, only 9% of these family members had taken CPR due to their family member's heart attack.

Reports from several communities with large numbers of people trained in basic life support have shown that more than 40% of patients with out-of-hospital heart attacks can be resuscitated successfully with prompt use of CPR.

"Because of the increased risk of coronary heart disease and sudden death in older people, it is of particular importance for these individuals and their immediate families to receive CPR training." Dr. Goldberg explained. "Our study clearly highlights the need for additional CPR training and emergency preparedness among family members of patients with coronary heart disease. Efforts must be made to encourage these family members to seek CPR training."



DEAN'S MESSAGE

Florida - a land of plenty?

Plenty? Plenty of what? Sunshine and orange juice? Beaches and other tourist attractions? Agriculture? Or health manpower? How many are enough? Enough to meet the needs? Needs of whom? Physicians, nurses, pharmacists, physical therapists, or dentists? The wealthy? The middle-income people? The medically indigent?

In the mid-1960s, a national health manpower shortage was predicted for the 1970s and 1980s if steps were not taken to boost the number of health professionals in our nation. As a result, for example, the number of medical schools has increased from 86 to 127 and the number of graduates has more than doubled. Other health professions have experienced large increases also. Simultaneously, physicians from other nations immigrated to the United States and many American young men and women enrolled

in foreign medical schools, and nonphysician providers gained increased responsibility for patient care (usually through legislation). In the late 1970s, the Federal government authorized a three-year analysis of physician needs of the nation in 1990 and beyond by the Graduate Medical Education National Advisory Committee (GMENAC). Using both a "demand" model and a "needs" model, the GMENAC Report predicted a general oversupply of physicians in the nation by 1990. Albeit, some specialties were predicted to have shortages, most specialties were judged to have a surplus.

Over the intervening years, several events have occurred: (1) Many existing medical schools have stablized or reduced enrollment. (2) More rigid requirements have been applied to the ability of a foreign national to immigrate to the nation and practice medicine. (3) The pool of applicants to medical schools has decreased. (4) Approval standards for many specialty residency programs have increased for quality purposes. (5) State licensing authorities are reviewing their requirements for licensure in order to increase standards. (6) Increased activity by the nonphysician providers to erode into the traditional physician's responsibilities has occurred. (7) Some hospitals have decreased the number of residency positions. (8) The Educational Commission for Foreign Medical Graduates (ECFMG) has revised its examination and will offer its new examination in 1985 which is reputed to be more rigorous than their current examination. (9) The Federation of State Boards of Medical Examiners will offer a two-part examination in 1984 which also will be more rigorous than the current FLEX. (10) Third parties are recognizing increasingly more nonphysician providers for reimbursement. Other changes, such as prospective payment and professional liability crises, undoubtedly will affect the equation of health manpower supply.

Instead of ruminating about our dilemma of health manpower and while attempting to alter the current state of affairs, is it not reasonable to consider a positive approach? When the industrial era of our nation reached maturity in the late 19th century, our industrial leaders searched and found additional consumers — the export trade. It was the "export phenomenon" that gained this nation the title as the industrial and technology center of the world.

While our medical care system is one of the world's leaders in quality, and clearly is in technology, we are feuding internally about "whose turf is whose" and "we have too many." Should we not consider the oversupply problem an opportunity to help solve a need in the Caribbean Basin via the exportation of health manpower!

Our Caribbean neighbors do not enjoy a resonable standard of health care. With expanding populations and decreasing resources, health care has become critical. Have you ever seen an NMR or CAT scan image from Haiti? When was the last time that you treated childhood tuberculosis? Are hundreds of nutritional deficiency syndromes part of your practice? How many Caribbean Basin children or adults with leukemia have benefited from bone marrow transplantation or even renal transplantation? Other parts of our globe are even worse.

Would an iniatitive by Florida medicine, in conjunction with other agencies, benefit our neighbors? Would it be beneficial to the Florida House of Medicine to take a bold, positive step and consider a Caribbean initiative . . . food for thought. . . .

William B. Deal, M.D.
Dean and Associate Vice President
for Clinical Affairs
College of Medicine
University of Florida
Gainesville

WORTH REPEATING

Movers and shakers?

I have a confession to make. I read Ann Landers. I've never written to her but I do read her column. Most of the time I think she gives real good, solid, common sense advice and when her expertise is stretched, she has excellent resources to quote. Recently however, one of these resources' comments gave me reason to ponder. Dr. Norman Shumway was called upon to respond to the query of a concerned mother of a medical intern. She could not understand the wisdom of an educational system that placed obligations on its trainees that pushed them to a constant state of physical and mental exhaustion. Dr. Shumway excused such practices first by remarking that such trainees were seldom called on to make life and death decisions in such a state of exhaustion, that the young doctors were pushed by a desire to gain as much clincial experience as possible, and that "most of them would rather take care of patients than either sleep or eat." He went on to define real shakers and movers as "individuals with total commitment," those who would do "big things" as compared with the rest who would do "lesser things." With all respect for Dr. Shumway who is unquestionably a mover and shaker and has accomplished very big things, I am not sure that quality is essential in order to be an effective physician and one who also may do big things. A physician must have an uncommon commitment when compared with counterparts in other professions and vocations and he or

she must be prepared to function at times well beyond limits set by fatigue but foolish is the one who permits this to be a "way of life." It indicates an attempt to function beyond one's capacity. I also can not believe that one learns best in a state of fatigue. If then, placing such extreme demands on our residents is not needed to prepare them for such a rigorous life ahead and if it does not promote the best learning environment, who do it? Well, I will concede that some shakers and movers are needed to maintain progress. Perhaps this is the way to separate out and identify them.

At about the same time an editorial appeared in *Surgical Rounds*, written by Dr. Mark Ravitch. Now I admire Dr. Ravitch very much and this is not to be considered critical. The gist of his editorial was a comparison, admittedly sacriligious, of departments of surgery and certain professional football clubs. Both rise to a pre-eminent position, maintain it for a time, then inevitably decline. He compares the Chief of the Department to the quarterback but also aptly notes that he also must be playing manager, coach, and recruiter. He must recruit his team, train his team, and maintain his team, all the while Playing, Leading, and Inspiring. He must be the brightest star but surrounded only by bright stars.

I recall my introduction to the internal medicine rotation in medical school. We were told by one of the professors that he was interested in the top ten students in the class. The rest of us could tag along but we need not expect any personal attention. I wonder if our educational system has not been obsessed with developing the stars. Stars do reflect light and glory on their mentors. However, not all aspiring doctors wish to be movers and shakers or professors, and thus they are filled with an ambivalence. Somehow, the impression is made, that if they do not have such aspirations they are failures, or at least second rate.

I fear some doctors never overcome this mental complex and substitute goals other than the ones Drs. Shumway and Ravitch envision. There must be other ways to define greatness.

James K. Conn, M.D.
Tallahassee

Reprinted with permission from The Capital Medical Society *Newsletter*, June 1984.

Time for a pep talk

At the March, 1984 meeting of the Lee County Medical Society a discussion was held on the outlook for the practice of medicine. At that time, a rather bleak picture was painted in the medical environment of tomorrow with anticipated surpluses of physicians, the proliferation of alternate health care delivery systems, government intervention in control of health care financing and probable loss of freedom of choice by the physician.

Well, we have already seen some of these things occur and others are going to be here shortly. Unfortunately, many physicians are becoming disenchanted and are feeling powerless to stop what appears to them to be the inevitable dismantling and irreparable damage to our profession. Against this background of gloom and doom, let us pause a moment, as this long hot summer begins to come to an end and reflect upon the things that make the practice of medicine a joyous, fulfilling and noble calling.

Everyday, every physician has uncounted opportunities to dispense the best of what medicine stands for and represents. This we can and should continue to do.

Each of us, regardless of our years in the profession has acquired knowledge as we have experienced life, and this knowledge assumes meaning which cannot be arrived at through the operation of reason.

When I get a little discouraged at events, however frustrating, I like to remember the following:

"What a man knows at fifty that he didn't know at twenty boils down to this — the knowledge of age is not the knowledge of formulas or forms or words, but of people, places and actions, a knowledge not gained by words or rules or regulations but by touch and sight and sound, victories and failures, sleeplessness, devotion and love — the human experiences and the emotions of this earth. And perhaps too, a little faith and reverence for a greater spiritual presence we cannot see."

At a time when the outlook for medicine looks grim, take heart. Don't dwell upon the negatives but continue to strive to make positive changes in our professional lives.

Remember that William Osler lived by the creed "Our main business in life is not to see what lies dimly at a distance but to do what clearly lies at hand."

Joseph P. Fiore, M.D.
Fort Myers

Reprinted with permission from *The Bulletin* of the Lee County Medical Society, September 1984.

The EPCOT syndrome

Prestigious medical journals continually publish correspondence on intriguing occupational, hobby or travel-associated syndromes. I have repeatedly encountered disorders with a major Florida attraction as the common denominator — the EPCOT

Center. On direct inquiry, patients so afflicted gave a history of unaccustomed activity during trips to this vacation Mecca. It included lengthy walking, prolonged standing in lines, and the carrying of heavy purses or shoulder-bags for extended periods.

It is suggested that physicians inquire about such a trip to Disneyworld or World Fair when the following unexpected components of "the EPCOT syndrome" are encountered:

E — Embolism (pulmonary)
P — Phlebitis of the lower extremities
C — Chest wall pain
O — Os calcis or other foot discomfort
T — Tendinitis (bicipital or left lateralepicondyle); trochanteric (hip) bursitis

Having presented this negative aspect, doctors should not discourage the joy of this novel Florida attraction, provided it is coupled with the appropriate precautions . . . especially for retirees.

H.J. Roberts, M.D.
West Palm Beach

Reprinted with permission from *The Palm Beach County Medical Society Bulletin*, August 1984.

American Diabetes Association

The American Diabetes Association through its service, education and research programs, gives help today and hope for tomorrow to all children and adults with diabetes. YOU can help support these projects by calling your local DIABETES ASSOCIATION, listed in your telephone directory.
CALL TODAY!

Heart Healthy Recipe

FRESH MUSHROOM SOUP

1 pound fresh mushrooms
2 tablespoons oil
2 cups water
2 cups nonfat dry milk
1 teaspoon onion flakes
1 tablespoon parsley flakes
1 tablespoon flour
1 tablespoon sherry
freshly ground black pepper to taste

Slice caps and stems of mushrooms in thick pieces. Heat oil in a heavy saucepan and sauté the mushrooms quickly until just crisp tender.

Combine all other ingredients in blender and mix until thick and foamy. Add mushrooms and blend again at lowest speed for 4 or 5 seconds or until mushrooms are chopped into fine pieces but not pulverized.

Pour the mixture back into the saucepan and heat slowly, stirring with a wire whisk to keep from burning. Use an asbestos pad if soup is to be left on the stove.
Yield: about 1¼ quarts
Approx. cal/serv.: 1 cup = 180
Variation

Spinach Soup: Substitute 1 10-ounce package of frozen chopped spinach for the mushrooms. Cook spinach until it is just broken up and follow recipe for mushroom soup. Serve dusted with nutmeg.
Approx. cal/serv.: 1 cup = 175

Heart Healthy Recipes are from the Third Edition of the American Heart Association Cookbook. Copyright © 1973, 1975, 1979 by the American Heart Association, Inc.

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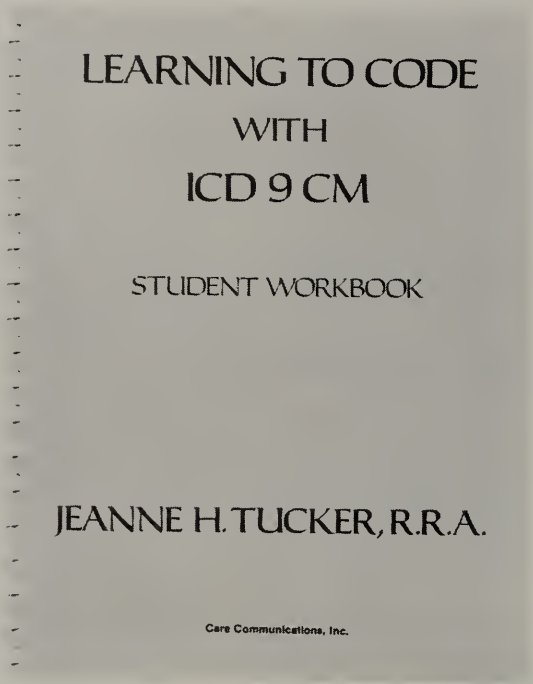
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BOOK REVIEWS

Book Review Editor — **F. Norman Vickers, M.D.**

The Consumer's Book of Health - How to Stretch Your Health Care Dollar

By Jordan Braverman, 305 pages. Price $11.95, The Saunders Press, 1982.

The health care consumer in 1984 is faced with many complex problems such as, dwindling medical insurance; mounting physician bills; escalating hospital charges; charges of Medicare and Medicaid ripoffs; impairment of the health care professionals; unavailability or maldistribution of nursing homes and home health care agencies, and a veritable rainbow of abbreviated and alphabetized agencies and systems of health care. So, too, are many physicians, nurses, pharmacists, technicians, and hospital personnel often bewildered by the explosion of new technology in medical care and related fields. *The Consumer's Book of Health* is an encyclopedic guide book through the complexities of seeking proper, quality care from appropriate resources for the average lay person. Obtaining dental and physician care, private health insurance, hospital care, nursing home care, home health care, and hospice care and prescription drugs, along with sound advice on Medicare, Medicaid, health maintainence organizations, and second opinion surgical programs are all explained and discussed in considerable detail.

Published in 1982, the statistics, data, and explanations of technology in the text are generally quite current and "state of the art" although the section on prescription drugs lists the 14 most frequently prescribed brand name drugs (and their generic equivalents) for 1979 and the list of 12 common antibiotics in the same section is only a partial list and from a source published in 1980.

This text will be a frequently used addition to the library of any physician in primary care and his office staff. More so, the bewildered patient (and patient's family) can use the book as a roadmap to reach rational decisions in the complexities of health care services, programs, and institutions through which he passes as he seeks medical care of the highest quality at reasonable cost in an American health care system where he has little control and usually even less understanding and knowledge.

Harold L. Ishler Jr., M.D.
Clearwater

● Dr. Ishler is in private practice of Family Medicine.

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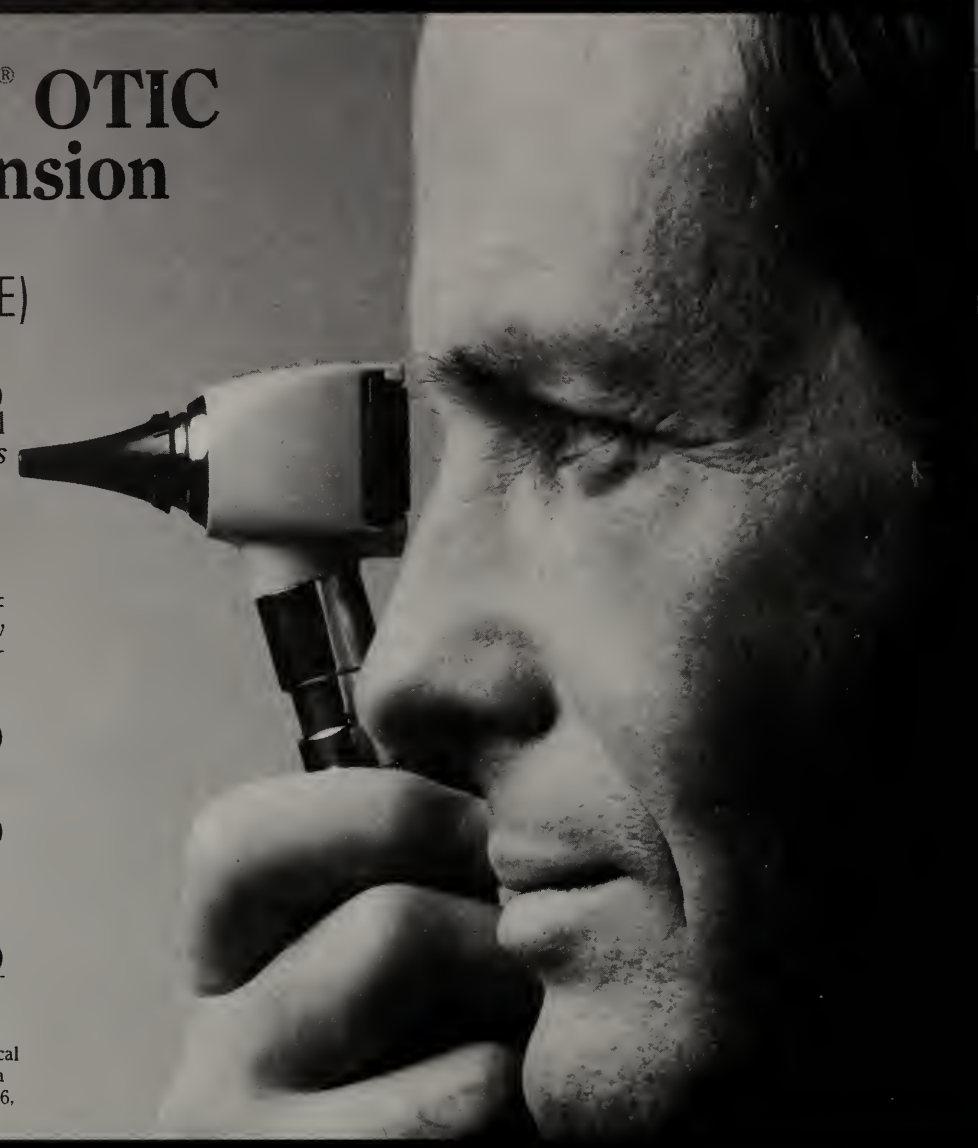
EFFICACY RATES FOR OTIC SUSPENSION AND OTIC SOLUTION (COMBINED RESULTS FROM 4-CENTER STUDY)

	Clinical Efficacy
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Total ears	93
Responders	91 (97.8%)
Solution	
Total ears	107
Responders	104 (97.2%)
Combined suspension and solution	
Total ears	200
Responders	195 (97.5%)

Adapted from Cassisi et al.[1]

REFERENCE:

1. Cassisi N, Cohn A, Davidson T, et al: Diffuse otitis externa: Clinical and microbiologic findings in the course of a multicenter study on a new otic solution. *Ann Otol Rhinol Laryngol* 86(suppl 39, pt 3):1-16, 1977.



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The vehicle contains the inactive ingredients cetyl alcohol, propylene glycol, polysorbate 80, water for injection and thimerosal (preservative) 0.01%.

Indications: For the treatment of superficial bacterial infections of the external auditory canal caused by organisms susceptible to the action of the antibiotics, and for the treatment of infections of mastoidectomy and fenestration cavities caused by organisms susceptible to the antibiotics.

Precautions: This drug should be used with care in cases of perforated eardrum and in long-standing cases of chronic otitis media because of the possibility of ototoxicity caused by neomycin.

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The vehicle contains the inactive ingredients cupric sulfate, glycerin, hydrochloric acid, propylene glycol, water for injection and potassium metabisulfite (preservative) 0.1%.

Indications: For the treatment of superficial bacterial infections of the external auditory canal caused by organisms susceptible to the action of the antibiotics.

Precautions: This drug should be used with care when the integrity of the tympanic membrane is in question because of the possibility of ototoxicity caused by neomycin.

Adverse Reactions: Stinging and burning have been reported when this drug has gained access to the middle ear.

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Contraindications: These products are contraindicated in those individuals who have shown hypersensitivity to any of the components, and in herpes simplex, vaccinia and varicella.

Warnings: As with other antibiotic preparations, prolonged treatment may result in overgrowth of nonsusceptible organisms and fungi. If the infection is not improved after one week, cultures and susceptibility tests should be repeated to verify the identity of the organism and to determine whether therapy should be changed.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, such as chronic otitis externa, it should be borne in mind that the skin in these conditions is more liable than is normal skin to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching, it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

Precautions: If sensitization or irritation occurs, medication should be discontinued promptly. Patients who prefer to warm the medication before using should be cautioned against heating the solution above body temperature, in order to avoid loss of potency.

Treatment should not be continued for longer than ten days. Allergic cross-reactions may occur which could prevent the use of any or all of the following antibiotics for the treatment of future infections: kanamycin, paromomycin, streptomycin, and possibly gentamicin.

Adverse Reactions: Neomycin is a not uncommon cutaneous sensitizer. There are articles in the current literature that indicate an increase in the prevalence of persons sensitive to neomycin.

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Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

Americans are unique . . . really unique!

Americans are unique, I mean really unique. We are like no other people in the world, because we are a glorious mix of every kind of people in the world. We resist categorization because we are so many different thoughts and energies.

Americans reflect the complexities of all nationalities. We are not a homogenous grouping of Danes, or Russians or Chinese, but rather we are a crazy, perplexing heterogeneous grouping called American. We are blacks, whites, all religious persuasions; a veritable smorgasbord of every known nationality, color and creed.

Our national spirit is a curious mix of noble human endeavor and human failure. It is the genius of Jefferson's Declaration of Independence and the anquish of Lincoln's Gettysburg Address. It is our nations prosperity and its soup lines. It is the pain of too many bloodied battlefields, and the scepter of fear that we are not yet free of wars' tyranny. It is all our nations battles won and lost; a summation of our hopes, our greatness and our human pettiness.

As Americans we are constantly examining, restructuring and redefining our purposes and goals, both as a nation and as individuals. We have worked at being tolerant, at understanding, at equality. Yet our history teaches us that these lessons have been learned most often the hard way.

We are a nation of doers — movers — changers. Give us a dream, a goal and we'll work to make it happen. We are a nation of individuals, unique, but not always comfortable with each others uniqueness — that difference. So we have to stretch our hearts, our minds and abilities — and once again America takes another step toward the realization of human potential.

We are a nation of conservatives, liberals, blue collar, white collar and Michael Jackson fanatics. We make room for the Jerry Falwells and the Madeline O'Hares. Fifty American hostages in Tehran stirred American passion to such a degree, that the rest of the world once again pondered this crazy nationality — American.

Our form of government has incurred any number of revolutions, from the American to the Sexual. American politics is as diverse, kinetic and alive as the people it reflects. It is the sum of all the parts that give any reasonable definition to what it means to be an American. It encompasses all of our past and present, and it shapes our future. We are a part, you and I, of the greatest human experiment known to mankind. We are the doers — the movers — the changers. Vote November 6th.

Carolyn C. Spore
State Legislative Chairman

Listen, this is important. You see your insides down there? Sure, your heart and your brain and all that stuff is there. But look at your lungs! I mean they are important! Without your lungs, nothing works! So don't smoke. Because smoking, oh, it's terrible! Your lungs get darker and get damaged. Smoking makes your lungs work harder and harder until, whew! You can't breathe at all! So don't smoke. That's all.



Sid Caesar

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Summary of the FMA Board of Governors Meeting October 9-14, 1984

The following is a summary of the major actions taken by the Board of Governors at its meeting October 9-14, 1984.

THE BOARD:

Florida Physicians' Insurance Reciprocal

Received a report that an agreement had been reached between the FMA and Physicians Insurance Company of Ohio (PICO) and the State Insurance Department for a plan to provide an ongoing physician-owned professional liability program for Florida physicians. Subsequently, the rehabilitation plan for the Florida Physicians' Insurance Reciprocal was submitted by Insurance Commissioner Bill Gunter to the Circuit Court of the Second Judicial District in Tallahassee and was approved by the Court on October 25, 1984. Under the plan, the Insurance Department will enter into a management contract with PICO to provide management for the FPIR now and after the completion of the rehabilitation phase on December 31, 1984. The company will be converted to a stock company at the earliest possible date in 1985. The FMA has agreed to participate as a minority stockholder in the company when it is converted to a stock company.

Also reviewed in great depth the problems encountered by the Reciprocal and directed that a "Big Eight" national accounting firm be retained to conduct an in-depth review of the finances and operation of the company and report its findings to the Board at the earliest possible date, and further, that the findings of the review be reported to the FMA membership when completed.

Reason '84

Expressed great disappointment by the decision of the Florida State Supreme Court in removing Amendment 9 from the November General Election ballot and condemned the Court's action as being highly politically motivated. It was noted, however, that there were many positive accomplishments gained from the Campaign, including a great public awareness of the severity of the professional liability problem in Florida, as well as an open acknowledgement of the problem by prominent state officials, including the Governor and leadership of the Legislature who realize the professional liability problem must be resolved.

In addition, the Florida Bar has extended a formal offer to work with the FMA in seeking solutions to the professional liability issue. The Board also acknowledged with sincere gratitude the extensive involvement and commitment to the Campaign by the FMA membership and FMA Auxiliary.

Future Actions for Tort Reform

Determined that the Association continue to exert every effort to permanently resolve the professional liability crisis. The Board authorized:

1. That the FMA President immediately appoint a special Blue Ribbon Panel to be comprised of the Council on Legislation and other prominent individuals to define and recommend a statement of policy for future tort reform efforts that will include specific legislative recommendations, constitutional initiative recommendations, petitions to the Supreme Court, and report its findings to the Board of Governors at the earliest possible date;

2. That pursuant to the recommendations of the Blue Ribbon Panel, meetings be requested with the Governor, the Florida Bar and legislative leadership to obtain a concensus regarding a petition to the Supreme Court in respect to the contingency fee system;

3. That consideration be given to the feasibility of attempting to have petitions signed during and prior to the November 6 General Election that would include those appropriate constitutional amendments as recommended by the Blue Ribbon Panel;

4. That every effort be made to obtain a commitment from the Governor and/or legislative leadership to place on the Agenda for the special November Session of the Legislature, a resolution of the professional liability crisis subject to the development of a proposed legislative program.

COUNCIL AND COMMITTEE REPORTS

COUNCIL ON LEGISLATION

Health Care Cost Containment

Determined that the FMA place maximum emphasis on developing a plan of action, both legislative and executive, to be considered in addressing the health care cost issue in 1985.

Hospital Staff Privileges

Referred the issue of hospital staff privileges for non-M.D. health professionals to the Committee on Health Manpower for study and recommendations.

Pharmacists Prescribing Drugs

Authorized the FMA leadership to meet with the leadership of the Florida Pharmacy Association to discuss the issue of pharmacists prescribing drugs.

Gubernatorial Vetoes

Supported efforts to sustain vetoes by Governor Graham during the 1984 Legislative Session relating to an appropriation of $150,000 to establish a College of Chiropractic, legislation mandating insurance coverage for chiropractic services and legislation authorizing dentists who complete an anesthesia residency to administer non-dental anesthesia.

COUNCIL ON MEDICAL ECONOMICS

Freestanding Emergency Centers

Approved in principle the FMA working in concert with the University of Florida Center for Health Policy Research in conducting a survey of freestanding emergency centers in Florida.

Standardized Health Claim Form

Approved the revised Standardized Health Claim Form developed in concert with the State Department of Insurance, Florida Hospital Association, and various component health insurance companies in Florida and the AMA, and directed that a copy of the form be disseminated to the FMA membership.

Workers' Compensation

Referred to the Council on Legislation for review the recommendation that the FMA seek repeal of the section of the Workers' Compensation Law that establishes a three-member panel.

Approved and referred to the Council on Legislation for appropriate action the recommendation that FMA seek repeal of that section of the law which mandates that Workers' Compensation reimbursement shall have statewide applicability.

COUNCIL ON MEDICAL SERVICES

Committee on Health Manpower

Adopted as goals for the Committee on Health Manpower:

— Identify those allied health groups that anticipate expanded activity through legislation or regulatory means;

— If possible, identify the goals of each allied health group;

— Develop an adequate data base for use by FMA, the staff and communicating with allied health groups;

— Develop a data base on physician manpower in Florida with identification of areas of shortages and what steps are being taken to correct these shortages;

— Develop a roster of expert witnesses who will be available upon short notice to represent FMA at legislative hearings;

— Cooperate with other agencies and groups to resolve problems with foreign trained health professionals.

"Medi-File" Card

Approved sending a copy of the "Medi-File" card to each FMA member with a letter explaining its purpose and use. The "Medi-File" card is a public relations and education program for the elderly developed in cooperation with the FMA Auxiliary to provide an easily accessible way of recording information on prescription drugs being taken by patients over 65 years of age.

Primary Care Program Initiative

Urged the Department of Health and Rehabilitative Services to continue its flexible policy in the evaluation of grants under the primary care program initiative (Laws of Florida 84-35) and further, of the importance of involving the private practice community and educational institutions in the development of primary care program initiative.

EMS Legislation

Approved and referred to the Council on Legislation for determination of the appropriate level of FMA support of the recommendation that FMA seek the enactment of EMS legislation that will establish the concept of regional designated trauma centers in Florida, create an up-to-date system of poison control centers and encourage statewide implementation of the 911 emergency telephone system.

Health Manpower Shortages

Adopted the following procedure for review and comments on proposed designations of health manpower shortage areas in Florida referred to the FMA by the U.S. Department of Health and Human Services.

1. The request for comment, along with the original application and other supporting papers supplied by HHS, will be forwarded immediately to the secretary of the appropriate county medical society.

2. The material will be accompanied by a letter from the Committee on Health Manpower requesting the county medical society to respond directly to the Department of Health and Human Services with a copy to the Committee. The cover letter will offer the Committee's assistance in corresponding with HHS if assistance is desired, and include the county health department on any communication.

3. In the case of proposed designations involving dental services, the Florida Dental Association will be provided with copies of all correspondence simultaneously.

4. The FMA headquarters will maintain a file on all proposed designations, and the essential components of all cases will be reported from time to time to the Committee on Health Manpower and the Council on Medical Services.

School Entry Health Examinations

Directed that the Department of Health and Rehabilitative Services be advised that the FMA strongly objects to the interpretation of Section 232.0315, Florida Statutes, which authorizes chiropractors to perform school entry health examinations, and supported the policy that all such examinations be completed by a licensed Doctor of Medicine or Doctor of Osteopathy.

Fingerprinting of Children

Endorsed programs of voluntary fingerprinting of children as an aid in identifying missing persons.

Child Abuse

Encouraged the FMA membership to participate in promoting recognition of, and education concerning, child abuse in both family and institutional settings.

Methadone Programs

Urged the Florida Department of Health and Rehabilitative Services to employ a knowledgeable and qualified individual to monitor compliance with, and exceptions to, the 1984 regulations governing methadone treatment programs.

Prescription Abuse Data Synthesis Project (PADS)

Recommended to the Department of Professional Regulation that it look into the possibility of deputizing members of the triage committee provided for under the FMA's policy on drug diversion identification and intervention.

Legislation of Heroin

Expressed strong opposition to the legalization of heroin as proposed in HB 5290 for use in controlling pain for terminal patients.

Dupont Pharmaceuticals

Commended Dupont Pharmaceuticals for its current campaign to alert pharmacists to the potentials for drug diversion through fraudulent prescriptions.

Physician Responsibility re Prescription Drugs

Requested that FMA members be reminded of their responsibility to cooperate fully with pharmacists in ascertaining the legitimacy of individual prescriptions whether ordered by verbal or written means, and to verify these prescriptions with the pharmacist personally whenever possible.

Drug Diversion Education

Authorized the Council on Scientific Activities to assist the Committee on Substance Abuse in forming a work group of physicians that would identify needs, set goals and plan curricula for the education and reeducation of physicians in the areas of prescription drugs and prescription drug diversion.

National Commission on Correctional Health Care

Endorsed the program of the National Commission on Correctional Health Care for accreditation research and training in correctional health care. The Commission, which includes representatives of several national medical and health organizations including the AMA, plans to continue the jail health care accreditation program begun by the AMA several years ago.

COUNCIL ON SPECIALTY MEDICINE

Specialty Group Legislative Programs

Approved the recommended legislative objectives for the Florida Society of Ophthalmology and referred these to the Council on Legislation for

consideration of the appropriate category of FMA support, including the defeat of any legislation that would authorize optometrists to use or prescribe legend drugs in the diagnosis or treatment of medical problems of the eye, opposition to legislation that would authorize optometrists hospital staff privileges, and opposition to any legislation that attempts to change the present law allowing medical examiners to remove corneal tissue under certain conditions.

Approved the recommended legislative objectives of the Florida Society of Anesthesiologists and referred these to the Council on Legislation for determination of the appropriate category of FMA support, including legislation that would ensure that certified registered nurse anesthetists be supervised by a physician or preferably be medically directed by an anesthesiologist; ensure that staff privileges are not mandated for nurse anesthetists; opposition to any legislation which would permit dentists to give anesthesia for non-dental procedures; and continue efforts to pass meaningful tort reform.

Specialty Group Recognition

Approved continuing recognition for the following specialty groups who have met the criteria established by the FMA House of Delegates for recognition by the Association:

Florida Society of Clinical Oncologists
Florida Society of Dermatology
Florida Gastroenterologic Society
Florida Society of Neonatal-Perinatologists
Florida Society of Neurology
Florida Orthopedic Society
Florida Chapter, American Academy of Pediatrics and the Florida Pediatric Society
Florida Society of Plastic and Reconstructive Surgeons
Florida Society of Thoracic and Cardiovascular Surgeons
Florida Urological Society

Naturopathic Practice

Expressed support for legislation prohibiting any further licensing of naturopathic practice.

Specialty Group Representation in the House of Delegates

Determined that the FMA Board of Governors recommend to the House of Delegates for consideration at its next Annual Meeting that each member of the Council on Specialty Medicine or their alternate be allowed one vote in the FMA House of Delegates.

Licensing of Physicians

Reaffirmed the FMA's opposition to any legislation that would allow in special cases for physicians to bypass state licensing boards to practice medicine in Florida, and referred this to the Council on Legislation for appropriate action.

Confidentiality of Patient Records

Expressed opposition to any legislation or request that would allow for the release of the confidential portion of patient medical records.

PRO

Received a status report on the FMA's protest to the Health Care Financing Administration for its award of the PRO contract in Florida to the Professional Foundation for Health Care of Tampa.

Instructed FMA Legal Counsel in coordination with the FMA's Washington attorneys to continue the protest and make every effort to seek an early decision by the General Accounting Office and a reversal of the decision of the Health Care Financing Administration in awarding the contract to the PFHC. The Board further directed that the FMA continue to pursue the lawsuit filed under the Freedom of Information Act for release of all necessary documentation regarding the PRO contract from the Health Care Financing Administration. The Board further directed that the matter of the award of the Florida PRO contract be referred to the American Medical Association and that the AMA be advised of the FMA's deep concerns about the adverse national implications resulting from the manner in which this law is being promulgated by the Health Care Financing Administration, and further, that this information be conveyed in an appropriate resolution to the AMA House of Delegates at its Interim Meeting in December.

COUNCIL ON SCIENTIFIC ACTIVITIES

FMA Annual Meeting Scientific Symposium

Approved a symposium, "Quality Medicine in a Rapidly Changing Environment" to be held in conjunction with the FMA 111th Annual Meeting on Thursday, May 2, 1985, from 4:00 p.m. to 5:00 p.m., and requested that no other activities be scheduled at that time.

CME Reporting

Requested that the Council on Scientific Activities reexamine the process of CME reporting and the need to involve the county medical societies.

Participation of Specialty Groups in Scientific Sections

Requested the Council on Specialty Medicine to examine the participation requirement for specialty societies in the Annual Meeting Scientific Program.

COUNCIL ON HOSPITAL MEDICAL STAFFS

Council Membership

Approved appointments for two representatives from each FMA medical district to serve on the newly established Council on Hospital Medical

Staffs from nominations submitted by county medical societies.

COMMITTEE ON MEMBERSHIP DEVELOPMENT

Florida State Medical Association

Extended an invitation to the Florida State Medical Association to send an observer with privilege of the floor to future FMA Annual Meetings.

COMMITTEE ON PROGRAMS AND PRIORITIES

Regional Meetings

Received the initial report of the Committee on Programs and Priorities resulting from five regional meetings held throughout the state by the Committee, with representatives from county medical societies within each region. These regional meetings were held in Jacksonville, Pensacola, Orlando, Tampa and Miami for the purpose of receiving comments concerning a broad range of FMA activities and programs and organizational structure. The FMA Executive Committee, which according to the By-laws serves as the Long Range Planning Committee of the Association, will hold a special meeting to review and act on the report. The Executive Committee will then submit its recommendations to the Board on each of the recommendations of the Programs and Priorities Committee.

Council on Hospital Medical Staffs



In May 1984 the FMA House of Delegates approved a recommendation of the Board of Governors that a Council on Hospital Medical Staffs be established. The Bylaws were amended to include this Council and to give the Council a vote in the House of Delegates.

The decision to establish this Council was made after a review of the complex problems facing medical staffs in Florida and a detailed study of the AMA Council on Hospital Medical Staffs, which was established in 1982. It will provide a forum for addressing the dramatic changes that are occurring in our health care delivery system. There are 217 acute care hospitals in Florida. Of these, 77 are proprietary, 88 are nonprofit, and 52 are government owned. The rapidity of change in Florida is especially dramatic because of the high percentage of Medicare beneficiaries (over 18%), the cost containment efforts of the federal government in Medicare and Medicaid programs and those of business coalitions in the private sector.

The Bylaws' amendment provides for a Council of nine members, two from each of the four medical districts and a chairman appointed by the President. The district members are appointed by the FMA Board of Governors from nominations received from the component county medical societies. Council members must be Florida Medical Association members in good standing. This Council, as do all other FMA councils, reports to the Board of Governors.

The Council will provide for representation of hospital medical staffs and serve in an advisory capacity to hospital medical staffs throughout the state. At least twice annually, representatives of hospital medical staffs will have the opportunity to meet with the Council to discuss common issues and concerns. The Council will develop and maintain information on issues of common concern to medical staffs and distribute data on successful approaches to problems.

Because of economic pressures brought about by prospective pricing such as DRGs, PROs, HMOs, PPOs and business coalitions for health, hospitals are paying more attention than ever to the make-up of their medical staffs. Many hospitals are keeping a detailed profile of each member of the medical staff. Others are going into joint ventures with members of the medical staff to develop facilities for ambulatory care as a replacement for inpatient care. Other joint ventures may include HMOs, medical office buildings and diagnostic centers.

Some hospitals are looking carefully at the total number of physicians on their medical staff and the specialty mix of these members. Others are developing mechanisms for applying "golden handcuffs" to members of the medical staff, thus binding them tightly to the hospital.

I believe that the future economic survival of both the hospitals and the physicians depends on a satisfactory working relationship between them. This Council on Hospital Medical Staffs provides a way whereby this relationship can be established.

I have appointed Thomas M. Daniel, M.D., as Chairman of this Council, and members have now been designated by the Board of Governors from nominations of the component county medical societies.

Dr. Daniel has prepared a detailed manual which is based on his experience as a participant in the AMA Council on Hospital Medical Staffs, long participation in organized medicine and active involvement in hospital medical staff and community affairs in Clearwater. This manual will be considered at the Council's upcoming organizational meeting.

After reviewing this manual, I am convinced that I made the right choice in appointing Dr. Daniel. He brings enthusiasm, expertise and dedication to this Chairmanship that will ensure effective performance by the Council.

The major issues to be addressed by this Council include: lack of medical staff voice in hospital planning and in hospital governing board decisions; effect of changes in hospital ownership on medical staffs; competition between hospital ambulatory services and office based practices; hospital diversification into other profit making activities; closed medical staff arrangements and/or exclusive contracts; interpreting and complying with JCAH standards; role of nonphysician health care providers in the hospital; interspecialty jurisdiction in delineation of privileges; and hospital cost containment.

Goals that will be considered by the Council for 1985 include: encouraging the development of county hospital medical staff committees under the jurisdiction of the county medical societies, and informing the membership of activities of the Council through a quarterly newsletter.

I am pleased to note that there will be a very close relationship between the local county Committees on Hospital Medical Staffs and the county medical societies. There is no reason for there to be competition between them. Each county medical society will be strengthened in its ability to represent the interests of its members by the development of these committees.

Dr. Daniel and I have discussed the possibility of competition between this new Council and the FMA — we do not see this problem developing. The reporting mechanism of the Council is very clear through the Board of Governors to the House of Delegates.

Now is the time for unity and adaptability among the members of the Florida Medical Association. I urge all of you to support this Council and the county committees.

Let me reemphasize the unity theme of my administration, **One Profession — One Association — One Future.** The establishment of the Council on Hospital Medical Staffs will certainly support this theme.

Frank C. Coleman MD

Acknowledgment of our heritage

Again it is the time of year when one's obligations should be expressed for the religious heritage bequeathed us by our forefathers, the pilgrims, who leaving their homes for a foreign land, spent a cold winter with little food or shelter, and then after the gathering of their first harvest set apart a special day for rendering thanks to God for the bountiful blessings bestowed on them.

A comprehensive anthology of all the best that has been written about this intensely American holiday reveals some surprising origins and facts. Through the ages, in the land of Canaan, the children of Isreal inherited many traditions and wrote in the book of Judges "and they went out into the field and gathered their vineyards and went into the house of their God." This Jewish feast of Tabernacles celebrating the harvest was also an act of worship, somewhat similar but not entirely akin to the harvest festival of ancient Greece, and was followed centuries later by Anglo-Saxons holding their "harvest-home" as a high point of the year in rural England.

The first authentic harvest festival in the New World was held in the fall of 1621. During the preceeding winter the new arrivals had been sorely tried by severe weather; the snow fell often and deep and less than half of the original 101 settlers remained alive. Suffering cold, hunger and disease, they lived onboard the Mayflower while forages on land by the men found game and berries and other things to eat. When spring arrived they planted corn and peas, wheat and barley and anxiously waited for them to grow, knowing their lives depended on the success of these crops. To their joy the harvest in September was bountiful and Governor Bradford ordered a three day celebration. Undesirable settlers arrived the next year without enough food and supplies, and the colonists at Plymouth, sharing their edibles, underwent a second winter even more gloomy than the first. Again seeds were planted in the spring but May brought a drought and it appeared that their crops would fail. The Governor ordered a day of fasting and prayer and a long refreshing rain spared the young plants. To show their gratitude to God at harvest time the pilgrims set aside a day of prayerful thanks to God and this day, November 23, 1623, is thought to be the birth of our present Thankgiving.

Years went by and immigrants from Europe populated towns and cities in the colonies as they expanded westward. Many of these colonists had difficulty in breaking ties or severing loyalty to their home lands, nevertheless a desire to govern themselves prompted the "Declaration of Independence" and war with England began. Following a winter of want and harrowing anxiety, the capitol in Philadelphia fell into the hands of the British. General Washington could foresee little hope of feeding or even protecting his shivering troops in Valley Forge. Two more bitter winters settled over the New World before the British could be defeated, and the war for independence won. The Continental Congress then proposed several days to commemorate the victory, and in 1789 George Washington designated November 26 with a proclamation declaring that "it was the duty of nations to acknowledge the providence of Almighty God" and established our first official national Thanksgiving day. Thomas Jefferson did not continue the custom but as time went by other Presidents followed Washington's example.

Widely observed in the northern states, it was practically unknown in the South, and in Virginia the Governor, in 1855, was successful in persuading his legislature to observe the holiday. The war

between the states dampened the enthusiasm of everyone for such a holiday until Lincoln, after the battle of Gettysburg, hoping that such an occasion would have a unifying effect issued a proclamation in 1864 naming the last Thursday in November as a nationwide day for Thanksgiving. The bleak days of reconstruction in the South provided little there to be thankful for and the autumn holiday was not officially observed by ensuing Presidents. The first World War to preserve global peace cast a gloomy spell over our country, followed by a boom and in turn followed by a severe depression in the 1930's, which stimulated Franklin Roosevelt to inspire the nation again by proclaiming the last Thursday in November as a national holiday for Thanksgiving.

A second world conflict again brought the horrors of war to our country and many men gave their lives in struggle for peace. In 1942, American soldiers in England introduced Thanksgiving to Great Britain when a service in Westminister Abbey by American Army Chaplains, with enlisted men as choristers, saw the American flag carried to the high alter.

Prosperity after this war saw another Thanksgiving presidential proclamation declaring gratefulness for the privileges and rights inherent in our way of life and in particular for the basic freedoms which our citizens enjoy without fear.

Thus through the years, through times of hardship and deprivation, poverty and suffering, amidst the grief of families whose sons, daughters and fathers died in wars to preserve our freedom, through the depths of depression and heights of prosperity, our Presidents and our people have given thanks for the preservation of those ideals of liberty and justice which form the basis of our national life and the eternal hope of international peace.

A little girl from Ireland visiting here said, "God must have loved the Americans an awful lot, he gave them so much to be thankful for." So Thanksgiving, a legacy of the pilgrams will be cherished this year and hopefully for many years to come.

C.M.C.

Are we doing too many procedures?

The notion that physicians may be overdoing things because of the profit motive is nothing new in medicine. Utilization and peer review committees have been on the scene for sometime looking over physicians' shoulders to make sure that the nation's health dollars are well spent. A few years ago, amidst highly publicized charges that physicians were doing excessive and unnecessary surgery, Medicare and a few fiscal intermediaries embarked on second opinion programs ostensibly to curb the itch of happy knife-wielders and to slow down the hemorrhage in health care dollars. Implicit in these activities is the idea that physicians, while generally honest and trustworthy, still need to be monitored to forestall potential abuses in our system.

As the furor over the issue of unnecessary surgery has gradually died down, and as review committees have become a fact of life in medical practice, increasing focus is now being shifted to a potentially more explosive problem: the question of whether physicians are doing too many procedures, whether indicated or not. The question is being raised in strident voices by the government, by insurance companies, and by a large segment of the medical profession. The fact that physicians are questioning their own colleagues makes the issue even more pressing and valid. Physicians are justifiably disturbed over the issue because procedures, like surgical operations, are expensive. At a time when the medical profession is being pressured from all sides to curb the cost of medical care, the financial strains caused by the performance of excessive procedures negate the efforts of many physicians to contain costs. Many physicians' groups, led by the American Society of Internal Medicine, are also questioning the exorbitant reimbursements for these procedures, particularly when juxtaposed to the modest rewards given by Medicare and insurance companies for non-procedural services.

The development of new technological advances for diagnosis and treatment of diseases has not always been the unqualified boon that the public has been led to believe. Physicians will be tempted to overdo things even for marginal indications as long as they know that they are going to get handsome financial rewards for their services. The tendency to overdo them is abetted by the fact that the guidelines for doing these procedures are not always clear-cut, and that makes it easy for physicians to stretch the indications. While utilization and peer review committees exist in most hospitals, they usually do not have the resources, the time, and the commitment to do the job that is really needed: to discipline those who abuse the system. Outside the hospital setting, the difficulties of reviewing physicians are even worse since there are no such review committees.

That there is mounting concern over the excessive utilization of procedures was evident at the recent annual meeting of gastroenterologists in New Orleans this June. The advent of flexible endoscopy has been one of the exciting advances in medicine in years and has placed gastroenterology at the cutting edge of a technological revolution where opportunities to do procedures are aplenty. But trouble is brewing. Dr. Thomas Hendrix, the president of the American Gastroenterological Association, urged members of his

specialty to re-establish their credibility, to examine and correct the problems coincident with technological advances, and to evaluate both the pricing and use of diagnostic and therapeutic procedures. Dr. Hendrix's words were strongly echoed in the same meeting by Dr. Bergein F. Overholt, president of the American Society of Gastrointestinal Endoscopy. Dr. Overholt was especially critical of the excessive fees, citing that gastroduodenoscopy can cost as much as $900, while colonoscopy as much as $650.

What is happening in gastroenterology is also happening in other specialties, where the advent of similar advances gives physicians the same wild abandon to splurge on procedures. While defensive medicine has been frequently cited as a reason for excessive testing, many physicians find it hard to swallow this line as accounting solely for the inordinate number of procedures being done. So-called state-of-the-art medicine also cannot account for this phenomenon, since nobody had shown that employing a big number of procedures is necessarily better medicine.

Apart from the ethical questions that it raises and the damage that it inflicts to the integrity of the medical profession, overutilization of procedures spawns other problems as well. The procedure-oriented areas are getting overcrowded at the expense of primary care specialties where medical manpower is most needed. Efforts to woo physicians away from these specialties will remain futile as long as a young physician knows that he can earn much more doing a procedure or two in one or two hours than by seeing 20 or 25 patients in six or eight hours. Where there is a built-in mechanism like this into the system, it is a foregone conclusion that there will be a glut of both specialists and procedures. This is a well documented fact. The best proof is in our university hospitals, where most of these procedures are being done, which are the most expensive in our medical care system.

There is another aspect of the problem that baffles everybody. As these procedures become safer and less time-consuming to perform, one would expect that they would become less expensive with time. But the opposite is happening: they become more expensive. We are overpricing ourselves at a time when the public expects medical care to be more affordable.

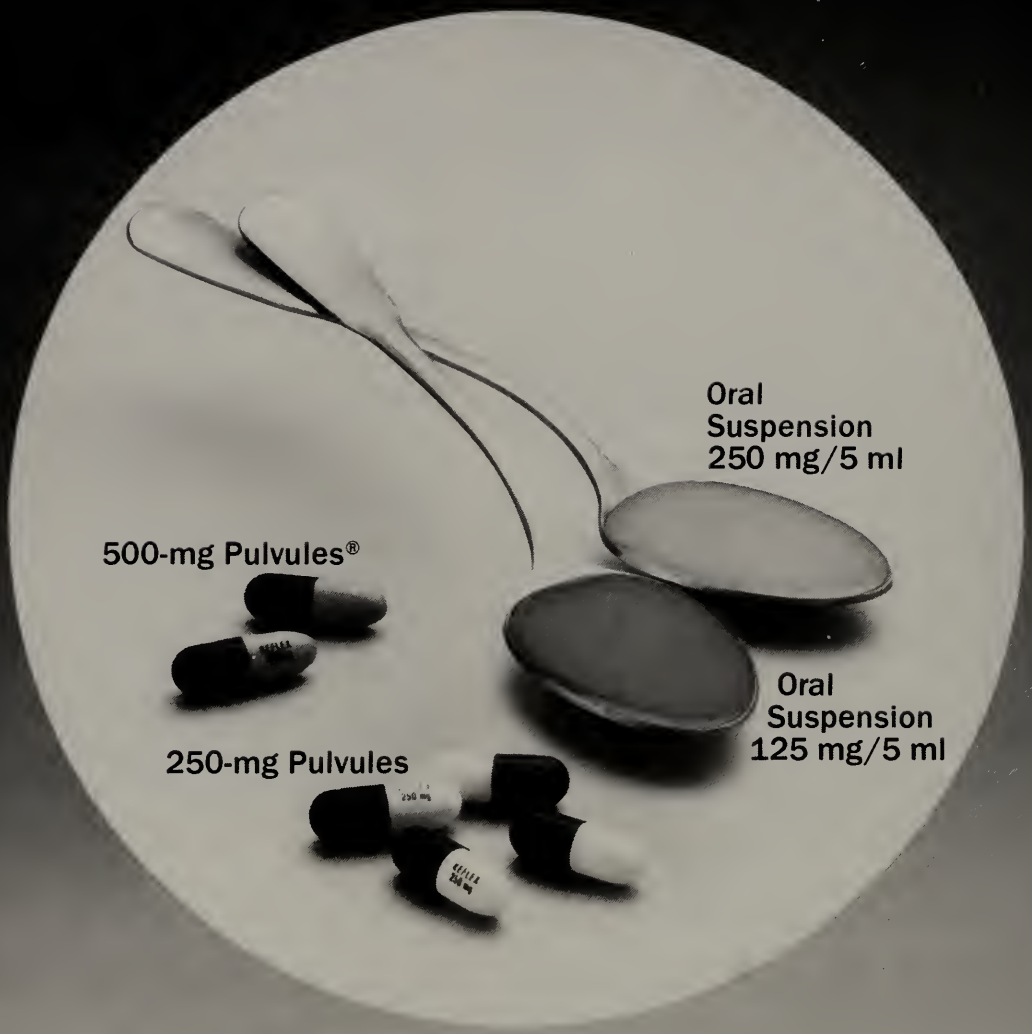
A big part of the problem is caused obviously by our skewed reimbursement system that places an inappropriate importance on procedures. Medicare and insurance carriers have been victimized by their own folly and are having a hard time trying to extricate themselves out of the mess. Now that imperatives to save money are quite strong, they may be forced to rethink their positions. With a fee freeze having become a reality, a downward adjustment of fees may not be far behind. More realistic reimbursement policies that reflect the true worth of these procedures, taking into consideration the time and skills involved, will go a long way toward bringing more sanity to the situation.

Overutilization, particularly when procedures are done for pecuniary reasons, is wrong, unethical, and inimical to the interests of the medical profession. It inflates already high costs and invites further third-party intervention at a time when physicians are already overburdened by regulations. The acknowledgment by leaders of medicine that the problem exists is a step in the right direction. But it should not stop there. Dr. Thomas Hendrix was right in calling upon physicians to re-establish their credibility. Medicine as a profession must remain pure and untainted by extraneous motives, while physicians must remain humanistic, not mercenary. Those of us who want to salvage our profession must close ranks and heed the call to stem the problem before it overwhelms us; if we do not, we will find ourselves deeper and deeper in a hole from which there may be no escape.

R.G. Lacsamana, M.D.
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CT directed biopsy of intracranial neoplasms: experience with Brown-Roberts-Wells stereotaxic frame

Steven A. Reid, M.D. and William A. Friedman, M.D.

ABSTRACT: Modern neuroradiologic imaging techniques are disclosing smaller intracerebral lesions with each successive generation of instrumentation. The location of these lesions or the patient's clinical condition may preclude resection via open craniotomy. Initiation of appropriate treatment, i.e. antibiotics, radiation, or chemotherapy, depends on accurate tissue diagnosis.

The Brown-Roberts-Wells stereotaxic system has become commercially available. This system utilizes data obtained via CT scan to precisely position instruments within the intracranial cavity. We describe our experience using this technology to biopsy intracranial lesions in 12 cases. In each case sufficient tissue was obtained to permit the initiation of appropriate therapy.

The Authors
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Computerized tomography (CT) has revolutionized the diagnosis of intracranial structural pathology. Increasing utilization of this technology has resulted in earlier diagnosis of neoplasms, many of which are small or located deeply within the substance of the brain. Histologic evaluation is essential for the proper management of cerebral mass lesions. Frequently these masses are located in critical areas of the brain that cannot be safely approached via craniotomy. In this situation, stereotaxic biopsy can result in adequate tissue diagnosis to permit initiation of therapy specifically directed against the lesion.

The BRW stereotaxic system, named after its developers Brown, Roberts, and Wells, has recently become commercially available.[1,2] In this paper we discuss our experience using this device at the University of Florida. Our first 12 cases are presented.

The BRW stereotaxic system • The BRW system was developed de novo from neurosurgical functional specifications.[1,2] It can be used with any CT scanner having an aperture large enough for "body scans." All computations are performed by a small hand-held computer and are completely independent of the CT scanner computer. This flexibility permits data processing in the operating room.

The BRW system has several key components.[1] A steel head ring is rigidly fixed to the skull using plastic and steel pins. These are vertically offset from the ring with graphite-epoxy struts. The ring is positioned well below the horizontal planes of the CT scan "slices" and does not, therefore, interfere with the x-ray beam. The head ring is applied under local or general anesthesia and remains in place during the scanning and subsequent stereotaxic biopsy.

The localizing system is composed of vertical and diagonal graphite-epoxy rods arranged in a roughly cylindrical configuration. This system is locked into place on the head ring during CT scanning. The graphite rods encircle the patient's cranium and appear in cross section as dense circles on each CT scan (Fig. 1). The x,y coordinates of these artifacts provide the computer with a frame of reference for precisely localizing points in 3-dimensional space relative to the head ring. When the scan is completed, the localizing system is removed.

The arc guidance system consists of an assembly of calibrated circular and semicircular stainless steel arcs. Each arc is rotated to an angle calculated by the computer. There are four axes in this configuration permitting four degrees of rotational freedom. This arrangement allows intracranial targets to be approached from virtually any angle. The arc guidance system contains a sleeve which serves as a support for a variety of biopsy instruments.

All calculations are carried out using a Hewlett-Packard HP41C programmable calculator. The role of this hand-held computer is to convert the x,y,z coordinates generated by the CT scan and the localizing system to the modified polar coordinates required by the arc guidance system.

A phantom simulator consists of a duplicate head ring permanently attached to a rigid 3-dimensional coordinate system. A movable steel point may be precisely positioned anywhere within this coordinate system. The arc guidance system is mounted on this phantom ring in the same configuration as on the patient's head. The steel point is moved to coordinates corresponding to those of the target within the tumor. An attempt to "biopsy" this dummy target is then carried out using depth and angle coordinates generated by the computer. This step allows the neurosurgeon to verify the accuracy of the arc angle settings and target depth prior to actual surgical intervention.

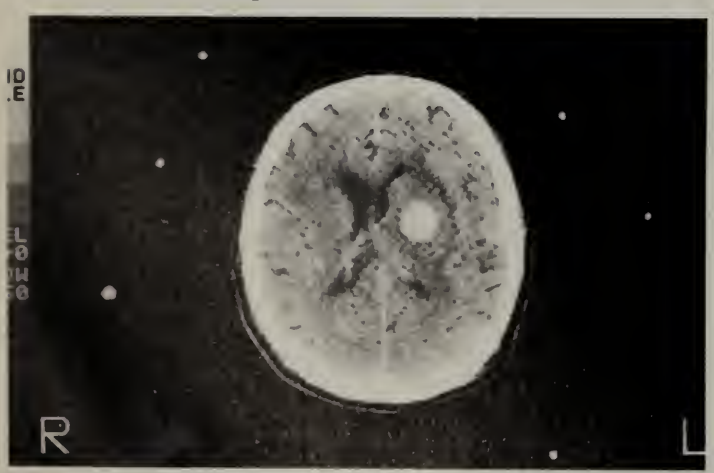


Fig. 1. — Localizing CT scan. This CT scan was used to localize target coordinates in Case 1. The dense artifacts in the periphery are the graphite rods of the localizing system. The CT cursor (square) is positioned at the target point in the center of the tumor.

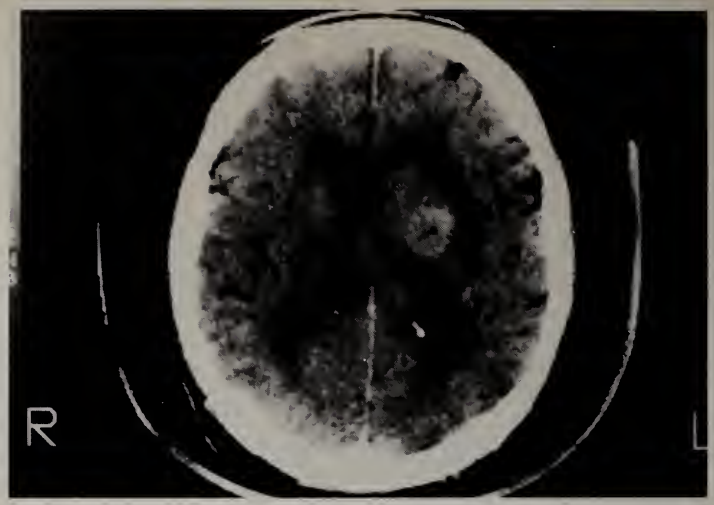


Fig. 2. — Postoperative scan. This scan shows Case 1 following stereotaxic biopsy. The lucency at the center of the tumor is air within the biopsy site. Comparison with Fig. 1 demonstrates the accuracy of this technique. Pathologic diagnosis was histiocytic lymphoma.

Clinical material and results • During the period from November 1983 to July 1984 a total of 12 patients at the Shands Hospital and the Gainesville Veterans Administration Hospital underwent CT directed stereotaxic biopsies of intracranial neoplasms. Table 1 summarizes these cases. In all but two cases, precise pathologic diagnosis was accomplished. In the two cases in which pathologic diagnosis could not be made with certainty, accuracy was still deemed sufficient to initiate radiation therapy. There were no permanent neurologic complications related to the procedure. There were three deaths in the series but these were probably not directly attributable to the biopsy technique (see Discussion).

Case reports — Case 1. — A 72-year-old white male presented to the emergency room with a four day history of mild right hemibody weakness and language disturbance. He had noted a mild headache for several days. There was no history of malignancy.

The general physical examination on admission was unremarkable. Neurologic examination revealed the patient to be awake, alert, and interested in his surroundings. He was oriented only to identity. His speech output consisted of many neologisms and paraphasic errors. He followed complex commands well and was able to repeat phrases. He had anomia and poor recent memory. Mild right central facial weakness was noted. Tremor of the upper extremities was present, worse on the right side. Pronator drift was prominent on the right. Muscle spindle reflexes were normal. Babinski's sign was present on the right. Sensory examination was unremarkable.

Radiologic evaluation included chest x-ray and bone scan, both unremarkable. CT of the brain revealed a contrast enhancing lesion in the left basal ganglia/internal capsule region (Fig. 1). Angiography revealed an avascular mass.

The patient underwent stereotaxic biopsy of the lesion via a left frontal burr hole (Fig. 2). Frozen section pathologic diagnosis was lymphoma. Permanent section and electron microscopic diagnosis was malignant lymphoma, large cell (histiocytic) type.

Table 1. — Patient data.

Patient	Age	Sex	Major Symptoms	Duration of Symptoms	Tumor Location	Pathology	Complications
1	72	M	Right hemiparesis Dysphasia	4 days	Left basal ganglia internal capsule	Large cell malignant lymphoma	None
2	48	M	Headache Weight loss	3 months	Periventricular third ventricle	Astrocytoma grade III	Transient recent memory deficit
3	60	M	Dementia Headaches	3 weeks	Splenium of corpus callosum	Probable glioblastoma multiforme	Infected pin site
4	69	F	Diabetes insipidus Confusion Lethargy	3 days	Suprasellar and left posterior periventricular	Large cell malignant lymphoma	None
5	61	F	Left hemiparesis	3 months	Deep right frontal lobe and basal ganglia	Glioblastoma multiforme	None
6	70	F	Right hemiparesis	6 weeks	Left parietal convexity	Glioblastoma multiforme	Pleural effusion
7	67	F	Unsteady gait Right homonymous hemianopia	3 months	Left parieto-occipital region	Astrocytoma grade III	None
8	62	M	Syncope Headache Tremor	4 years	Left thalamus and midbrain	Probable low grade astrocytoma	Pulmonary embolism - death (3 weeks postop)
9	19 mo	F	Hydrocephalus Status epilepticus	9 months	Occipital lobes and brainstem	Primitive neuroectodermal tumor	Death (2 days postop; probably due to shunt malfunction)
10	68	F	Left neglect	1 month	Deep right parietal lobe	Glioblastoma multiforme	Death (2 weeks postop)
11	40	F	Seizure	3 months	Deep left parieto-occipital region	Astrocytoma grade II	None
12	11	M	Right hemiparesis	3 years	Left basal ganglia	Germinoma	None

The patient had temporary, mild worsening of his deficits postoperatively with a transient period of SIADH. He underwent radiation therapy with 3000 rads to the cranium. He was discharged to a nursing home.

Case 2. — A 61-year-old white female noted acute onset of left hemifacial weakness three months prior to admission. This was followed one week later by left hemibody incoordination and dragging of the left foot on ambulation. She stated that she was sleepier than usual. There was no history of malignancy.

General physical examination was unremarkable. Neurologic evaluation revealed the patient to be awake, alert, oriented, and cooperative. No higher cortical function deficits were detected. The cranial nerves were normal except for a mild anisocoria (left pupil larger) and mild central facial weakness on the left. Motor examination revealed strength to be grossly intact. Left upper extremity pronator drift was noted. Dysdiadochokinesis was present on the left. Gait testing revealed mild weakness of the left foot dorsiflexors. Mild left hemibody hyperreflexia and Babinski's sign were noted.

Pre- and postcontrast CT scans revealed an abnormally dense mass with a relatively lucent center, located deep within the right frontal lobe (Fig. 3). This 5 cm lesion enhanced strikingly with contrast. It extended from approximately the right lateral suprasellar cistern diagonally upward and laterally to involve the deep frontal substance. It was centered at the genu of the internal capsule but also involved the head of the caudate nucleus, thalamus, and deep white matter. Review of cerebral angiography from the referring institution revealed tumor vascularity.

The mass was biopsied through a right frontal burr hole. Pathologic diagnosis was glioblastoma multiforme. Her neurologic examination remained unchanged. She was discharged four days later for outpatient radiation therapy.

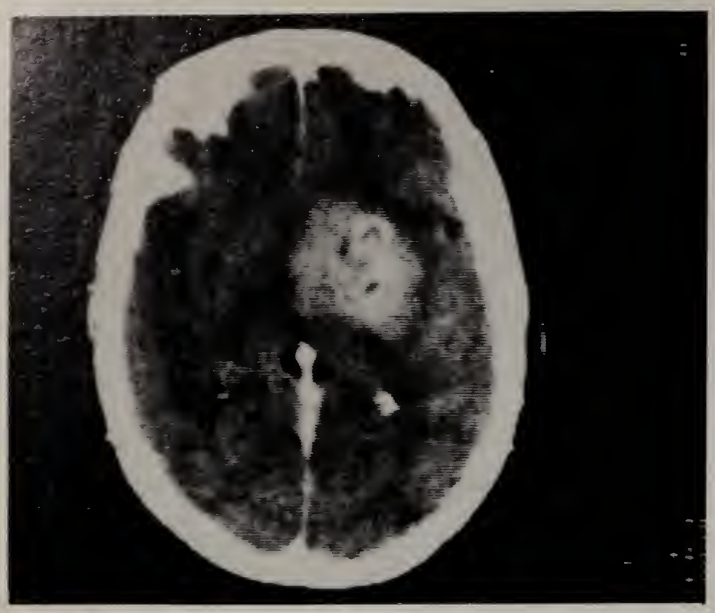


Fig. 3. — CT scan, Case 2. This scan shows the deeply located right frontal tumor of Case 2. It is centered at the genu of the internal capsule but also involves the head of the caudate nucleus, thalamus and deep white matter. Pathologic diagnosis was glioblastoma multiforme.

Case 3. — An 11-year-old white male presented with a three year history of progressive right hemiparesis. He complained of occasional evening headaches and also noted easy fatigability, especially involving the right leg. Past medical history was negative for significant illness.

General physical examination on admission was unremarkable. The patient was alert and well oriented with normal speech, memory, and calculations. The nasolabial fold was less prominent on the right side. Motor examination was remarkable for right hemiparesis, arm > leg, distal > proximal. The patient ambulated with a right spastic gait. Muscle spindle reflexes were hyperactive on the right and Babinski's sign was present on this side. Sensory examination was unremarkable.

Cerebral CT in August 1983 revealed a spontaneously dense mass lesion in the region of the left basal ganglia. Repeat CT scan in March 1984 revealed a slight increase in the size of the tumor, however, very little edema surrounded the lesion (Fig. 4). Cerebral angiography demonstrated a minimally vascular mass lesion in the region of the head of the caudate nucleus on the left. The lesion was biopsied through a left frontal burr hole. Pathologic diagnosis was germinoma. The patient was discharged on the third postoperative day to receive radiation therapy as an outpatient.

Discussion • Remarkable technological advances in neuroradiology have placed an increasing burden on neurological surgeons. The techniques of magnetic resonance imaging and computerized tomography are disclosing smaller lesions with each successive generation of instrumentation. Obtaining tissue from intracranial lesions is the province of the neurosurgeon. A tissue diagnosis is essential prior to initiation of potentially hazardous radiation or chemotherapy. There is no greater tragedy than the needless death of a patient whose misdiagnosed brain abcess was irradiated.

Generally it is preferable to resect intracranial lesions via craniotomy. In certain cases, this approach is unsuitable due to the lesion's location, the patient's general state of health, or other limiting factors. There are four major groups of patients in which stereotaxic biopsy is indicated.[3]

1. Patients with no prior history of tumor presenting with an unresectable single mass lesion such as midline tumors or tumors with diffuse hemispheric invasion.

2. Patients with no prior history of tumor who present with multiple intracranial lesions.

3. Patients with a known primary malignancy but without evidence of metastasis who present with a single unresectable intracerebral mass. Occasionally these lesions are not metastases from the primary tumor. For example, there is a higher incidence of meningiomas in breast cancer patients with brain tumors[4] and of lymphomas in patients who are immunosuppressed.[5] These patients are also susceptible to brain abcesses and intracerebral hematomas.[3]

4. Patients with a known primary malignancy, no evidence of extracerebral metastasis, and multiple intracerebral mass lesions. As above, these lesions may represent disease other than metastases. Before beginning radiation and/or chemotherapy, accurate tissue diagnosis may be desired. This is most easily accomplished via stereotaxic biopsy.

It is difficult to compare stereotaxic biopsy to open craniotomy with regard to morbidity and mortality.[3] As previously indicated, tumor location(s) and history of prior malignancy are key factors in selection of one or the other procedure. In general, those patients selected for stereotaxic biopsy harbor deeper tumors in critical areas of the brain or are suffering from worse systemic disease. The goal of craniotomy is usually total resection and possible

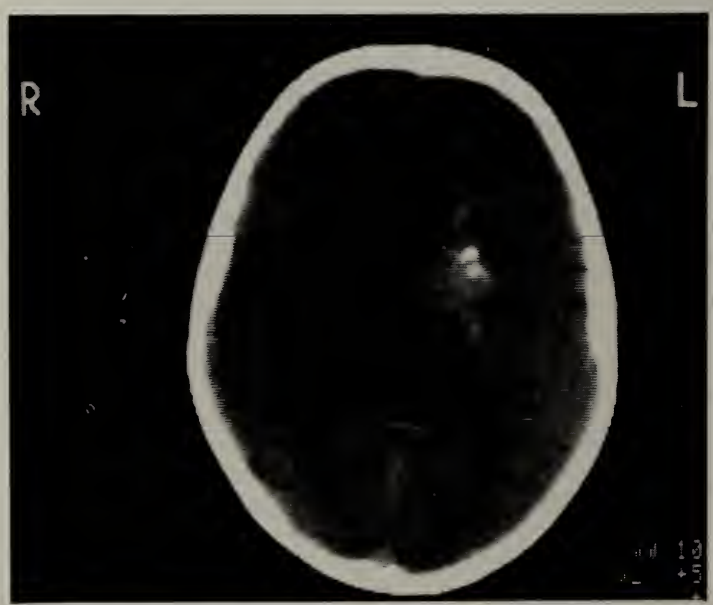


Fig. 4. — CT scan, Case 3. This scan shows the location of the tumor of Case 3 deep within the left hemispheric basal ganglia. Pathologic diagnosis was germinoma.

cure of the neoplasm. In contrast, the goal of stereotaxic biopsy is to render a tissue diagnosis so that other forms of therapy can be initiated.

Most of the complications in our series were temporary or trivial (Table 1). However, there were three postoperative deaths. The first of these was a 19-month-old girl with a massive primitive neuroectodermal tumor. She had undergone placement of a ventriculoperitoneal shunt several months earlier for treatment of hydrocephalus. Her recovery from the biopsy procedure was uneventful and she had a satisfactory postoperative course for the first 24 hours. Subsequently, she experienced apnea, bradycardia, and transtentorial herniation. It is likely that necrotic or proteinaceous debris from her cystic tumor obstructed the shunt valve, resulting in acute hydrocephalus.

The second death in our series was a 62-year-old man (Table 1). He underwent an uneventful stereotaxic biopsy and recovery and was discharged on the sixth postoperative day. Three weeks following biopsy while receiving radiation therapy, he suffered a fatal pulmonary embolus. Examination of the biopsy site at autopsy showed no evidence of hematoma. The pulmonary embolus may have been related to inactivity as a result of his brain tumor. It is doubtful that the biopsy procedure per se contributed to his death.

The third death in our series was a 68-year-old woman (Table 1). She had done well following stereotaxic biopsy of a glioblastoma. Approximately two weeks following surgery while receiving radiation therapy as an inpatient she suffered cardiopulmonary arrest. Her family did not consent to an autopsy. Postoperative CT scans showed no evidence of hemorrhage in the region of the biopsy. It is possible that she also succumbed to a pulmonary embolus.

The future holds great promise for stereotaxic neurosurgical procedures. Protocols are currently underway at the University of Florida for the stereotaxic implantation of radioactive sources within brain tumors (brachytherapy). In this way, the amount of radiation delivered to a tumor can be greatly increased while maintaining an adequate margin of safety for the surrounding tissues.[6-9] Gutin et al reported a 68% response rate in the treatment of metastatic or primary malignant brain tumors using implantation of high activity iodine-125.[6] Kandel et al have reported on the stereotaxic implantation of cryogenic probes for the cryotherapy of deeply located gliomas.[10]

The BRW system is capable of directing a probe to intracranial targets with a mean error of 1.8 mm.[2] This degree of precision is more than adequate for the placement of electrodes or for radiofrequency lesions in functional neurosurgical procedures. This technique may be applicable to the treatment of chronic pain, seizures, or movement disorders in the near future.

References

1. Heilbrun, M.P.; Roberts, T.S.; Apuzzo, M.L.; Wells, T.H. Jr., and Sabshin, J.K.: Preliminary Experience with Brown-Roberts-Wells (BRW) Computerized Tomography Stereotaxic Guidance System, J. Neurosurg. 59(2): 217-222, 1983.
2. Thomas, D.G.; Anderson, R.E., and du Boulay, G.H.: CT-guided Stereotactic Neurosurgery: Experience in 24 Cases with a New Stereotactic System. J. Neurol. Neurosurg. Psychia. 47(1):9-16, 1984.
3. Bosch, D.A.: Indications for Stereotactic Biopsy in Brain Tumours, SO Acta. Neurochir. (Wien), 54(3-4):167-179, 1980.
4. Schoenberg, B.S.; Christine, B.W., and Whisnant, J.P.: Nervous System Neoplasms and Primary Malignancies of other Sites, Neurology 25:705-712, 1975.
5. Penn, I.: Second Malignant Neoplasms Associated with Immunosuppressive Medications, Cancer 37:1024-1032, 1976.
6. Gutin, P.H.; Phillips, T.L.; Wara, W.M.; Leibel, S.A.; Hosobuchi, Y.; Levin, V.A.; Weaver, K.A., and Lamb, S.: Brachytherapy of Recurrent Malignant Brain Tumors with Removable High-Activity Iodine-125 Sources, J. Neurosurg. 60:61-68, 1984.
7. Gutin, P.H.; Hosobuchi, Y.; Phillips, T.L., and Stupar, T.A.: Stereotactic Interstitial Irradiation for Treatment of Brain Tumors, Cancer Treat. Rep. 65:103-106, 1981.
8. Bernstein, M. and Gutin, P.H.: Interstitial Irradiation of Brain Tumors: Review, Neurosurg. 9(6):741-750, 1981.
9. Mundinger, F.; Ostertag, C.B.; Birg, W., and Weigel, K.: Stereotaxic Treatment of Brain Lesions. Biopsy, Interstitial Radiotherapy (Iridium-192 and Iodine-125) and Drainage Procedures, Appl. Neurophysiol. 43:198-204, 1980.
10. Kandel, E.I.; Vavilov, S.B.; Peresedov, V.V., and Saribekian, A.S.: Stereotaxic Biopsy of Brain Tumor Using Computer Tomography, Zh. Vopr. Neirokhir. Iul.-Aug. (4) p. 3-8, 1981.

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Magnetic resonance imaging (MRI): overview

Michael J. Foley, M.D. and Lawrence R. Muroff, M.D.

ABSRACT: Magnetic resonance imaging (MRI) employs radio frequency waves and strong magnetic fields to produce clinically useful images. It is derived from the density and magnetic properties of nuclei rather than nuclear mass, as is the case with conventional x-rays. No ionizing radiation is utilized. A brief outline and overview of the history and physics of MRI as well as clinical applications and cost are discussed.

During the past decade there have been impressive developments in medical imaging. Advances in nuclear medicine, B-mode gray-scale ultrasound, and computerized tomography (CT) have dramatically improved the diagnostic evaluation of most pathological conditions. These techniques are largely the result of direct application of computers to medical imaging.

The imaging revolution began in 1973 when Sir Godfrey N. Houndsfield introduced CT,[1] a technology which uses digital computers to reconstruct clinically useful images from raw x-ray data. Recently, a new application of the computerized reconstruction technique has been developed: magnetic resonance imaging or MRI. Instead of using x-rays, MRI employs high-frequency radio waves and a strong (1.5 - 15 kilogauss) magnetic field to produce an image.[2]

Theoretically, MRI combines attributes of CT, ultrasound, and nuclear medicine. The image is derived from the density and magnetic properties of nuclei rather than nuclear mass as in x-ray. These magnetic properties change according to the chemical and physical environment surrounding the nuclei. Therefore, minor chemical changes in certain disease states may be detected and imaged prior to morphological changes; on the other hand, CT and ultrasound require substantial alterations in anatomy before pathology is visualized. Thus, as with nuclear medicine and positron emission tomography, MRI can detect biochemical, metabolic, and physiological changes.[3] However, it also has excellent physical resolution similar to ultrasound and CT scanners. Even more important is the fact that ionizing radiation is not employed to generate the image and, to date, no clinically apparent adverse effects have been reported as a result of magnetic fields and radio waves used for MRI clinical studies.[4,5]

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Prototype MRI imaging devices are being evaluated at several medical institutions in this country as well as in Europe and Japan. In Florida it is estimated that there will be approximately 15-20 MRI scanners by 1986.

History • The magnetic resonance properties of molecules were first studied by F. Bloch of Stanford[6] and E.C. Purcell[7] of Harvard. Both received the Nobel prize in physics in 1952. This method has been used by chemists and physicists for nearly 30 years to determine the molecular structure of pure homogeneous samples in vitro. The suggestion that similar techniques could be applied to noninvasive diagnostic imaging required imagination and technological expertise. Two American scientists, Raymond Damadian, a professor of medicine at the Downstate Medical Center of the State University of New York, and Paul Lauterbur, a professor at SUNY-Stonybrook, in papers published in 1971[8] and 1973,[9] were the first to postulate that MRI techniques could be useful in clinical medicine.

Many commercial firms have developed or are developing MRI units — Brucker, Diasonics, Elscint, Fonar, General Electric, Philips, Picker International, Siemens, Technicare, and Toshiba. Clinical trials on prototype magnetic resonance imaging devices have been ongoing for the past few years. All MRI prototype units currently in use produce images visually similar to CT scans. While as yet the MRI devices cannot produce images in all parts of the body with the fine detail of fourth generation CT scanners, this limitation is compensated for by MRI's ability to provide information on tissue states and physiologic functions.[10,11]

Physics • MRI is based on the fact that nuclei of atoms with an odd number of protons and neutrons behave like tiny bar magnets. When these nuclei are subjected to a static magnetic field, the nuclei precess (or spin) like a gyrating top around an axis in the direction of the applied field. The rate at which each nucleus precesses, or gyrates, is called that nucleus' resonant frequency (or Larmor frequency). This frequency depends on the character of the nucleus and the strength of the applied magnetic field. If radiofrequency energy is applied at right angles to the static magnetic field, those nuclei with the same resonant frequency as the interrogating radiofrequency energy will be perturbed to a higher energy state. This principle is best explained by the example of a swinging pendulum. If a series of forces is applied to the pendulum with the same frequency as its swing, the pendulum's motion becomes larger.[12]

When the exciting radiofrequency energy is removed, the perturbed nuclei return to their original state, giving off energy. The amount of energy that the nuclei give off is directly related to the density of the nuclei. This parameter can easily be measured, thus providing clinically useful information about the nucleus and its biochemical environment. Furthermore, the amount of time it takes the nuclei to return to equilibrium (their relaxation times) can be measured in two distinct ways to provide additional information of diagnostic significance. The relaxation times are called T-1 and T-2. T-1, or spin-lattice relaxation, characterizes the interaction between a nucleus and its environment (lattice). T-2, or spin-spin relaxation, describes the interaction between a nucleus and similar surrounding nuclei. Following the acquisition of relaxation times and proton density measurements, the data are analyzed by Fourier transform functions and computer algorithms similar to those used in computed tomography to reconstruct an image.[13]

Most elements have at least one reasonably abundant isotope whose nucleus is magnetic. In human tissues, images measuring H-1, C-13 and P-31 will be of higher quality than those produced using other resonating ions because of the relatively high concentration of these atoms within the body. Of these, H-1 is the most abundant. Proton images depend on the relative abundance of protons, so that tissues high in H-1 contents, such as fat, will produce strong signals, whereas tissues with small concentrations of H-1, such as bone, will produce little or no signal at all.

To date, there is no concensus as to the best method of obtaining images utilizing the MRI technique.[14] In a typical instrument (Fig. 1) there are large electromagnetic coils to produce the static magnetic field. Additional magnetic coils are added to produce field gradients, thus enabling spatial information to be obtained. Finally, a radiofrequency coil is wound around an insulated cylinder in the center bore of the magnet in order to produce the appropriate radiofrequency energy perpendicular to the main magnetic field. Large magnetic field strengths result in better signal-to-noise ratios. The nuclei resonate at greater frequencies when subjected to stronger magnetic fields and emit stronger signals. At very high frequencies, however, the radiofrequency signal is attenuated and, as a result, the quality of the resultant image is diminished. The optimal size of the magnet needed for clinical studies is still an unresolved issue.[15]

There are two basic types of magnets currently available to produce the main static field — resistive and superconductive. A third type employing a permanent magnet is also being evaluated for clinical use. Superconductive magnets are capable of providing greater detail and more biochemical information on molecular structure but they cost considerably more than resistive magnets, both to buy and to operate. Superconductive magnets use cryogenic materials,



Fig. 1. — The magnetic resonance imaging unit manufactured by Technicare bears a superficial resemblance to a computed tomography unit. However, because of the weight of the magnets, MRI units are much heavier and require a structural support of 1-1.5 tons per square foot.

usually liquid helium and liquid nitrogen, to bring the temperature of the electromagnetic coils down to nearly absolute zero since ultracold substances conduct electricity without resistance. Both the liquid helium and liquid nitrogen boil off during the cooling process and must be replenished periodically, a somewhat expensive and theoretically hazardous process.[16] Resistive magnets are less expensive initially but they are less stable and tend to drift; furthermore, they have large power requirements and energy costs that can be as great or greater than the operational costs for superconductive magnets.

The total time required to obtain good spatial resolution with MRI techniques is usually on the order of several minutes so that motion is presently an important limitation for MRI in certain parts of the body. Fortunately, with most systems, multiple images can be obtained simultaneously (Fig. 2). Also, an important advantage of MRI technique is that a variety of scan planes can be obtained without data loss or image degradation (Fig. 3).

Clinical applications • In the head and neck MRI appears to offer all the capabilities of x-ray CT as well as a number of additional advantages.[17] Conventional computed tomography is poor at differentiating gray and white matter. The differences in water and fat content of the gray and white matter, however, are sufficient to permit them to be clearly and distinctly visualized with MRI. Demyelination in white matter is easily detected, thus early and more subtle changes in multiple sclerosis can be diagnosed by MRI than is possible with CT (Fig. 4). When compared with CT, it is clear that MRI offers improved diagnostic efficacy in degenerative brain disorders, infarcts, and demyelinating diseases.[18] Since bones do not produce artifacts in MRI, it is an excellent means of imaging the posterior fossa when compared to CT where adjacent bone structure frequently causes artifacts.

MRI demonstrates the spinal cord distinct from the spinal canal without the need for contrast enhancement. Furthermore, the spinal cord and canal can be

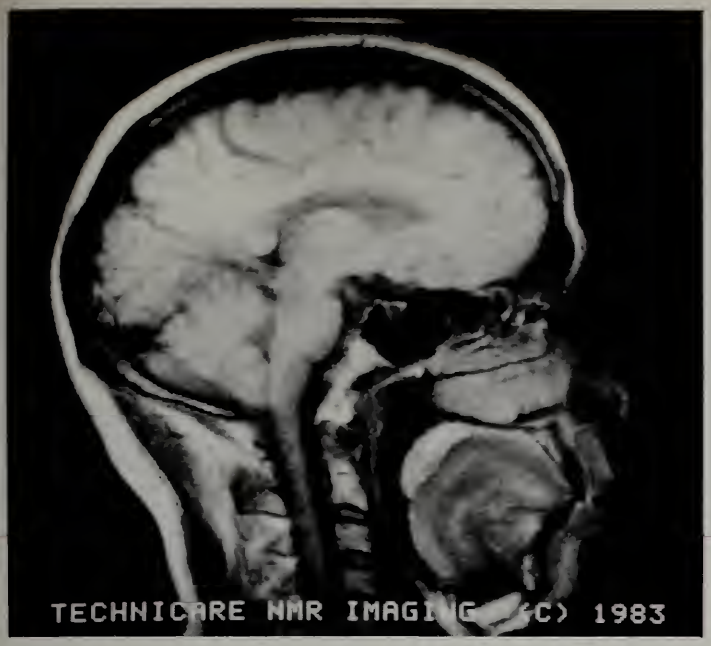


Fig. 2. — A sagittal slice demonstrating normal cranial and brain stem anatomy using a spin echo (SE) pulse technique at a 0.5 Tesla (T) magnetic field strength. Multiple images can be obtained simultaneously by MRI which facilitates the examination. Note the absence of artifacts and the clear visualization of the posterior fossa.

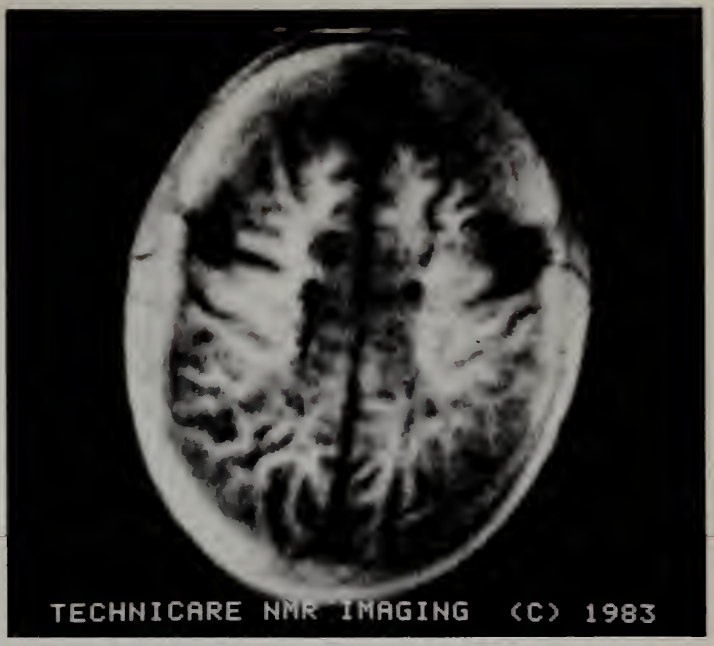


Fig. 4. — An axial slice of the brain illustrating the plaques of multiple sclerosis using an inversion recovery (IR) technique.

displayed in both the sagittal and coronal planes, in addition to the axial plane, without data loss or artifacts. This is not presently possible with reconstructed data in computed tomography. Even at this early stage in the development of magnetic resonance, it appears that in most instances MRI can replace CT in the evaluation of the brain. Soon, MRI may reduce the need for myelography and CT in the evaluation of spinal cord and intervertebral disc diseases.[18]

Because of the time required for image acquisition, the magnetic resonance image of the thorax and abdomen is degraded by motion. However, mediastinal structures and blood vessels are shown to excellent advantage with MRI (Fig. 5), and the differentiation of tumor from vascular structures should be more easily made by MRI than by CT.[19] Of the many possible MRI applications, few are more promising than the examination of the heart. Ischemia associated

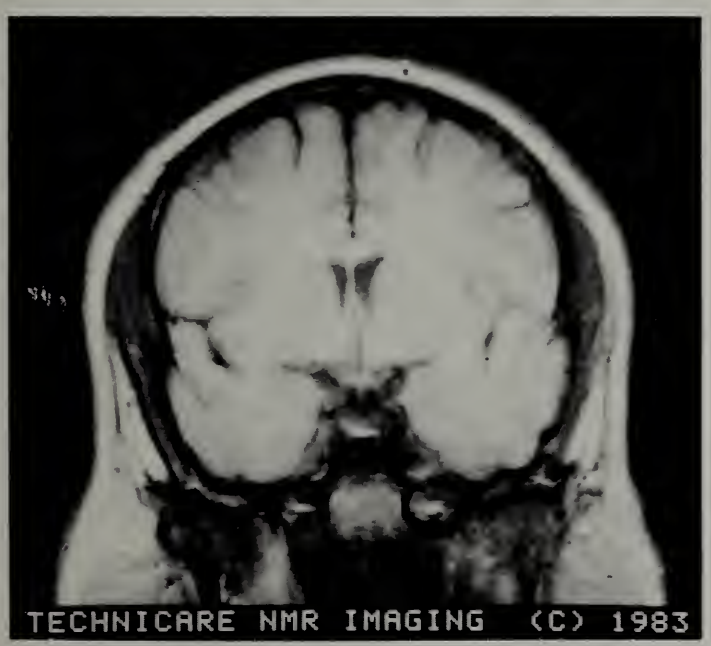


Fig. 3. — A coronal slice of normal cranial anatomy using a spin echo (SE) pulse technique at a 1.5 Tesla (T) magnetic field strength.

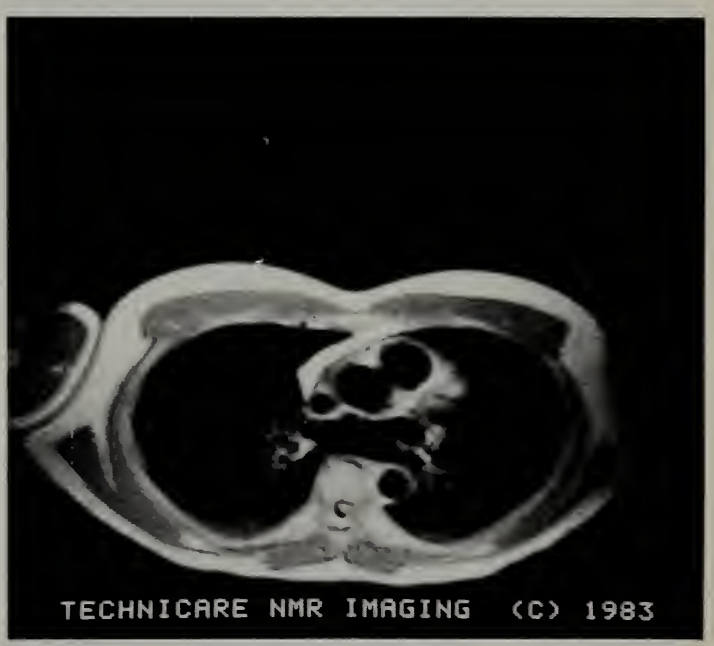


Fig. 5. — A transverse slice of normal cardiac anatomy using a spin echo (SE) pulse technique at a 0.5 Tesla (T) magnetic field strength.

with recent myocardial infarction can be demonstrated using MRI with and without manganese enhancement. The manganese distributes according to blood flow and will enhance the nonischemic myocardium relative to the ischemic myocardium.[20-22] Thus, it is possible to identify the myocardium with decreased blood flow and calculate the extent of involvement with greater accuracy than is now available by x-ray CT or radionuclide imaging. Cardiac gating can decrease motion artifacts significantly, thus providing exquisite anatomical information about the heart and its associated structures. Gating will require increased data collection times but may make it possible to diagnose septal defects, structural anomalies, and aneurysms, as well as evaluate myocardial motion and cardiac output.[21]

The full role of MRI in the evaluation of pulmonary, gastrointestinal, and genitourinary diseases has yet to be determined (Fig. 6). For example, MRI of the kidney is able to distinguish the cortex, medulla, and perirenal fat without contrast material. There is promise in differentiating hypernephromas from cancers metastatic to the kidney since hypernephromas have increased fat content.[23] Thus, the potential for MRI is its ability not only to detect pathology but to characterize it. Additional abdominal applications include the detection of liver neoplasms, cysts, and abscesses,[24] while MRI enhanced with paramagentic ions such as Fe-52 and Cu-63 shows some promise in the diagnosis of Wilson's disease, hemochromatosis, hemosiderosis and primary biliary cirrhosis.[25]

MRI can be utilized in the study of blood flow.[26] Normally flowing blood will be magnetized but will move out of the radiofrequency field by the time the image is obtained and, therefore, no signal will be recorded. In stenotic vessels the blood flow may be so slow that a signal can be imaged. In fact, it is possible to quantify blood flow on the basis of the signal received.[27,28] This fact demonstrates another advantage of MRI — blood vessels are distinctly imaged without the need for intravenous iodinated contrast which is essential in CT imaging.

Among its disadvantages, MRI utilizes high magnetic field strengths which preclude the presence of ferromagnetic materials both in the patient and in the scanning environment. Oxygen tanks, cardiac pacemakers, aneurysm clips and other life-support systems at the present time cannot be placed in the area of the magnet.[29] Therefore, critically ill patients and those with pacemakers or aneurysm clips cannot be scanned with MRI techniques. Fortunately, most joint prostheses are not ferromagnetic and therefore do not interfere with MRI imaging. Interestingly, most credit cards and automatic bank teller cards are encoded with magnetic information which can be easily erased when subjected to the strong magnetic field of MRI. Thus, storage for wallets and watches must be provided in MRI facilities.

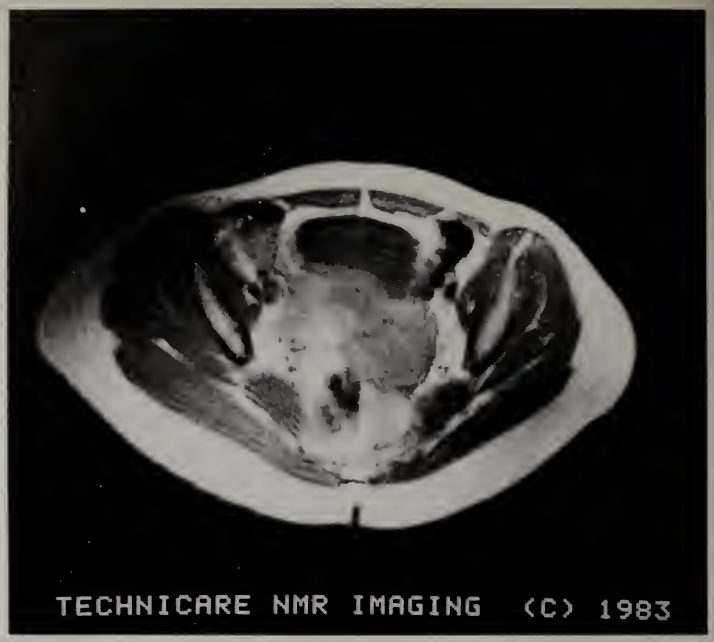


Fig. 6. — A transverse slice of the pelvis illustrating an endometrial carcinoma using a spin echo (SE) pulse technique at 0.5 Tesla (T) magnetic field strength.

Cost • MRI technology is expensive. At present the price of a resistive magnetic unit approaches $1 million while the cost of a superconducting magnet unit is from $1.5 - $2 million. This is somewhat more expensive than CT units. Furthermore the cost of site preparation for MRI is much higher than with computed tomography. These costs may vary from up to $500,000 for resistive magnets to as much as $750,000 to $1 million for a superconductive magnet.[30] There are two principle reasons for this expense: the weight of the equipment and the need for a nonferrous, radiofrequency-free environment. The floor loading requirements are from 1 - 1.5 tons or more per square foot. Thus, substantial structural support is usually required. Sizeable ferromagnetic structures such as elevators or cars near the installation site may distort the magnetic field significantly while radiofrequency waves intruding into the scanning environment may distort the resultant image. Therefore, a nonferromagnetic radiofrequency-free environment must be achieved to provide the most accurate image.[31-34]

Since MRI represents new technology and a substantial investment of funds, a certificate of need will be required. In most states, need methodologies and other substantive criteria for approval have not been established. Furthermore, at the moment there is no reimbursement from the federal government for performance of MRI examinations. Thus, the economic impact on the patient and on the entity operating the MRI unit is unresolved at present. Many academic institutions are either not charging for the studies or are being reimbursed at far below cost. Community installations, without appropriate research support, cannot exist under these uncertain

financial circumstances. Hopefully, sensible third party reimbursement will be instituted in the near future. Recognizing that the instrument and its installation will cost in excess of $2 million, what will be the cost to the patient for such an examination? It appears that each will require approximately one hour, limiting the number to 8-15 per day. By most accounting systems, the examination will cost from $400 - $800 per patient.[35] This cost, since it is not reimbursed by most third party carriers, is of great concern to the medical profession, hospitals, and health regulatory agencies to say nothing of the patient. Is this expenditure worth it? Preliminary data would indicate that there are many cost effective uses for MRI. It cannot, however, be used merely to confirm the presence of pathology seen on other studies. Rather the future potential for MRI lies in its functional and biochemical applications. The precise identification of pathology, quantification of physiological data, and the ability to assess early biochemical alterations are the strengths of MRI which should make it a medically useful, cost-effective modality. No medical technology has progressed so rapidly in so short a period of time, yet it appears that we have only begun to explore its clinical potential.

Acknowledgment

Magnetic resonance images are shown courtesy of the Technicare Corporation.

References

1. Houndsfield, G.N.: Computerized Transverse Axial Scanning (Tomography). I. Description of System, Br. J. Radiol. 46:1016-1022, 1973.
2. James, A.E. Jr.; Price, R.R.; Rollo, F.D., et al: Nuclear Magnetic Resonance Imaging: Promising Technique, JAMA 247(9):1331-1334, 1982.
3. Partain, C.L.; Price, R.R.; Patton, J.A., et al: Nuclear Magnetic Resonance Imaging: Overview, in Freeman, L.M. and Weissmann, H.S. (eds): Nuclear Medicine Annual, Raven Press, New York, 1983.
4. Budinger, T.F.: Nuclear Magnetic Resonance (NMR) in vivo Studies: Known Thresholds for Health Effects, J. Comput. Assist. Tomog. 5:800-811 (Dec.) 1981.
5. BRH Issues Guidelines for NMR Risks, American College of Radiology Bulletin 38:9, April 1982.
6. Bloch, F.; Hanson, W.W., and Packard, M.E.: Nuclear Induction, Phys. Rev. 69:127, 1946.
7. Purcell, E.; Torrey, H., and Pound, R.: Resonance Absorption by Nuclear Magnetic Moments in a Solid, Phys. Rev. 69:37-38, 1946.
8. Damadian, R.: Tumor Detection by Nuclear Magnetic Resonance, Science 171:1151-1153, 1971.
9. Lauterbur, P.: Image Formation by Induced Local Interactions: Examples Employing Nuclear Magnetic Resonance, Nature 242:190-191, 1973.
10. Pykett, I.L.: NMR Imaging in Medicine, Sci. Am. 246:78-88, 1982.
11. Young, I.R.; Bailes, D.R.; Burl, M., et al: Initial Clinical Evaluation of Whole Body Nuclear Magnetic Resonance (NMR) Tomography, J. Comput. Assist. Tomogr. 6:1-18, 1982.
12. Partain, C.L.; James, A.R. Jr.; Rollo, F.D., et al: Nuclear Magnetic Resonance (NMR) Imaging, W.B. Saunders, Philadelphia, 1983.
13. Slichter, C.P.: Principles of Magnetic Resonance, Springer-Verlag, New York, 1978.
14. Crooks, L.E.; Ortendah, D.A.; Kaufman, L., et al: Clinical Efficacy of Nuclear Magnetic Resonance Imaging, Radiology, 146:123-128, 1983.
15. James, A.E. Jr.; Partain, C.L.; Holland, G.N., et al: Nuclear Magnetic Resonance Imaging: Current State, Am. J. Roent. 138:201-210, (Feb.) 1982.
16. Alfidi, R.J.; Haaga, J.R.; El Yousef, S.F., et al: Preliminary Experimental Results in Humans and Animals with Superconducting Whole-Body Nuclear Magnetic Resonance Scanner, Radiology 143:175-181, 1982.
17. Bydder, G.M.; Steiner, R.E.; Young, I.R., et al: Clinical NMR Imaging of Brain: 140 Cases, AJR 139:215-236, 1982.
18. Brant-Zawadski, M.; Badam, J.P.; Mills, C.M., et al: Primary Intracranial Tumor Imaging: Comparison of Magnetic Resonance and CT, Radiology 150:435-440, 1984.
19. Herfkens, R.J.; Higgings, C.B.; Hricak, H., et al: Nuclear Magnetic Resonance Imaging of Cardiovascular System: Normal and Pathologic Findings, Radiology 147:749-759, 1983.
20. Brasch, R.E.: Work in Progress: Methods of Contrast Enhancement for NMR Imaging and Potential Applications: Subject Review, Radiology 147:781-788, 1983.
21. Kaufman, L.; Crooks, L.; Sheldon, P., et al: Potential Impact of Nuclear Magnetic Resonance Imaging on Cardiovascular Diagnosis, Circulation 67:251-257, 1983.
22. Higgins, C.B.; Herfkens, R.J.; Lipton, M.J., et al: Nuclear Magnetic Resonance Imaging of Acute Myocardial Infarction in Dogs: Alterations in Magnetic Relaxation Times, Am. J. Cardiol. 52:184-188, 1983.
23. Brady, T.J.; Burt, C.T.; Goldman, M.R., et al: Tumor Characterization Using 31-P NMR Spectroscopy, in Witcofski, R.L.; Karstaedt, N., and Partain, C.L. (eds): NMR Imaging, The Bowman Gray School of Medicine, Winston-Salem, 1982.
24. Brasch, R.G.: Methods of Contrast Enhancement for NMR Imaging and Potential Applications, Radiology 147:781-788, 1983.
25. Runge, V.M.; Stewart, R.G.; Clanton, J.A., et al: Potential Oral and Intravenous NMR Contrast Agents, Radiology 147:789-791, 1983.
26. Kolin, A.: Improved Apparatus and Technique for Electromagnetic Determination of Blood Flow, Rev. Sci. Instrum. 23:235-242, 1952.
27. Singer, J.: Blood Flow Measurements by NMR of Intact Body, IEEE Trans. Nucl. Sci. 27:1245-1249, 1980.
28. Garroway, A.: Velocity Measurement in Flowing Fluids by NMR, Appl. Phys. 7:L159-L163, 1974.
29. Saunder, R.D. and Orr, J.S.: Biological Effects of NMR, in Partain, C.L.; James, A.E. Jr.; Rollo, F.D., and Price, R.R. (eds): Nuclear Magnetic Resonance Imaging, W.B. Saunders, Philadelphia, 1983.
30. Holland, G.N.: Systems Engineering of Whole-Body Magnetic Imaging System, in Partain, C.L.; James, A.E. Jr.; Rollo, F.D., and Price, R.R. (eds): Nuclear Magnetic Resonance Imaging, W.B. Saunders, Philadelphia, 1983.
31. NMR Site Planning Guide, Technicare Corporation, Cleveland, Ohio.
32. NMR Site Planning Guide, Picker Corporation, Highland Heights, Ohio.
33. NMR Site Planning Considerations, General Electric Company, Milwaukee, Wisconsin.
34. NMR Tomography, Diasonics Corporation, San Francisco, California.
35. James, A.E. Jr.; Partain, C.L.; Rollo, F.D., et al: Nuclear Magnetic Resonance (NMR) Imaging: Potential and Technic, South. Med. J. 74:1514-1519, 1981.

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Toxic methemoglobinemia — an unpredictable intraoperative emergency

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ABSTRACT: A case report of toxic methemoglobinemia occurring during surgery is presented and the physiology and treatment of this relatively rare condition are discussed. Its occurrence is largely unpredictable but it may be anticipated rarely preoperatively by a careful past and family history. Prompt recognition by observation of chocolate-brown blood and determination of PO_2 and methemoglobin levels followed by immediate treatment with intravenous methylene blue are the essential elements of management.

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Intraoperative toxic methemoglobinemia is an uncommon, unpredictable, abrupt and alarming event, which almost always occurs without preoperative suspicion or warning. The clinical picture is rapidly developing cyanosis of the skin and viscera and darkening of the blood, the color progressing to an unmistakable chocolate brown. These changes appear in the presence of normal arterial PO_2. A recent experience illustrates the diagnostic problems and management involved with this entity.

Case report • A 69-year-old white female in previously good health presented for removal of a right ovarian cyst discovered during her annual physical examination. The patient had undergone a vaginal hysterectomy with repair of cystourethrocele and rectocele by one of us (JMI) in 1976. Preoperative evaluation was unremarkable. There was no family history or past history of unexplained cyanosis.

With induction of anesthesia, the patient was intubated utilizing benzocaine ointment. At the time of the incision into the peritoneum, 20 minutes after intubation, the blood was noted to be dark. Arterial blood gases were obtained immediately and the patient was placed on 100% oxygen. The arterial PO_2 was reported as 130 mm/Hg. A bilateral salpingo-oophorectomy was performed. In spite of the administration of 100% oxygen, the color of the blood remained dark and began to assume a chocolate-brown appearance. Repeat arterial blood gases were obtained and a methemoglobin level was performed on the sample because of a suspected methemoglobinemia. The arterial PO_2 was 300 mm/Hg and the methemoglobin determination was reported as 37% (normal less than 1%) confirming the diagnosis of acute methemoglobinemia. Methylene blue, 100 mg, was given intravenously. The color of the blood improved within several minutes. The operation was completed and the patient was transferred to the postanesthesia recovery room in stable condition. Repeat methemoglobin level in the recovery room was 1.3%. A level the first postoperative day was less than 1% and on the same day a hematology consultant advised no further therapy. The patient made

an uneventful recovery. A nicotinamide adenine dinucleotide (NADH) — methemoglobin reductase enzyme assay — obtained six weeks later was reported as "present," ruling out enzyme deficiency.

Careful questioning of the patient revealed that she had undergone dental procedures on several occasions under local anesthetics of unknown composition without adverse effect. A repeated family history was noncontributory. The patient and her family were informed of the nature of her disorder and a medical alert bracelet was obtained for her.

Discussion • The term methemoglobinemia describes that clinical circumstance in which more than 1% of the hemoglobin has been oxidized to the ferric form.

Cyanosis first appears at methemoglobin concentrations near 15%. Signs of hypoxia appear at levels near 50-60%.[1,2] Concentrations of 60-80% may be associated with vascular collapse, coma, and death.[1-4]

Methemoglobin is reduced mainly through the NADH — methemoglobin reductase system, maintaining a normal concentration of less than 1% (Fig. 1)[1,3] A second mechanism exists depending on nicotinamide adenine dinucleotide phosphate (NADPH) provided by the hexose monophosphate shunt which normally accounts for only 5% of the total reducing activity. Methylene blue can act as a cofactor to greatly accelerate this later reaction (Fig. 2).[1]

$$NADH + Hb\,Fe^{3+}\text{-}OH \xrightarrow[\text{reductase}]{\text{NADH - methemoglobin}} NAD^{+} + Hb\,Fe^{2+}$$

Figure 1

$$NADPH + Hb\,Fe^{3+}\text{-}OH \xrightarrow[\text{(cofactor)}]{\text{Methylene blue (tetramethylthionine)}} NADP^{+} + Hb\,Fe^{2+}$$

Figure 2

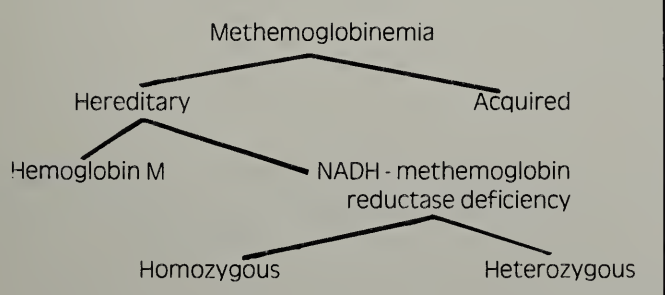


Fig. 3. — From Curry, S.: Methemoglobinemia, Annals of Emergency Medicine 11:214, 1982.

There are three distinct types of methemoglobinemia (Fig. 3). By far the most common is toxic or acquired methemoglobinemia which occurs when various drugs or other substances accelerate the oxidation of hemoglobin. In toxic methemoglobinemia, the hemoglobin alteration not only decreases the available oxygen carrying pigment but also increases the affinity of the unaltered hemoglobin for oxygen, thereby further impairing oxygen delivery and enhancing the symptoms.

Toxic methemoglobinemia may occur in genetically susceptible individuals. However, the disorder usually occurs in patients without genetic enzyme deficiency at conventional drug dosages as demonstrated by the reaction to topical benzocaine in this case report.

A vast number of substances including local and topical anesthetics has been implicated as precipitating factors in toxic methemoglobinemia.[5-9] Some of the more common ones are listed in Table 1.

The condition may also arise as a result of hereditary deficiency of NADH-methemoglobin reductase (congenital methemoglobinemia). Homozygotes for the NADH-methemoglobin reductase deficiency trait (autosomal recessive) have very little enzyme activity and must rely on less efficient conversion mechanisms. These individuals have chronic methemoglobin levels of 10-50%.[1,4] As a result they have a constant blue-brown cyanosis, the treatment of which is primarily for cosmetic purposes and is accomplished by increased daily oral intake of ascorbic acid — 300 to 600 mg daily — to increase nonenzymatic reduction of methemoglobin.[1-4] Heterozygotes for this trait are not usually clinically methemoglobinemic. Both phenotypes manifest an increased susceptibility to the methemoglobin producing properties of a wide variety of substances.

A third type of methemoglobinemia is that due to inheritance by dominant autosomal pattern of the hemoglobin M diseases in which the globin portion is structurally abnormal. Methemoglobin concentrations do not exceed 25% to 30%. There is no effective therapy for this disorder, but fortunately none is usually required.[1,4]

Treatment of toxic methemoglobinemia • The patient without serious signs of hypoxia requires only removal of the toxin. With the development of signs of hypoxia and/or methemoglobin levels greater than 30-60%, treatment with intravenous 1% methylene blue should be initiated promptly in dosage of 1-2 mg/kg over 5 minutes. The dose may be repeated in one hour if necessary. A total of no more than 7 mg/kg should be given as toxic effects may begin to

Table 1. — Agents reported to induce methemoglobinemia.

Nitrites and other direct oxidants	
Amyl nitrite	Food adulterated with nitrites
Sodium nitrite	Corning extracts
Nitroglycerin	Nitrous gases (arc welders)
Bismuth subnitrate	Well water (nitrates)
Ammonium nitrate	Postassium chlorate
Silver nitrate	
Aromatic amino compounds, nitro compounds, and other indirect oxidants	
Sulfonamides	Aniline Dyes
Sulfanilamide	Diaper marking ink
Prontosil	Dyed blankets
Sulfathiazole	Laundry markers
Sulfapyridine	Freshly dyed shoes
Sulfamethoxazole	Red wax crayons
Acetanilid	Naphthalene
Phenacetin	2-Anilinethanol
Acetaminophen	Topical anesthetics
Benzocaine	
Resorcinol	

Adapted from Wintrobe in Olson, M.L., McEvoy, G.K.: American Journal of Hospital Pharmacy 38:89, 1981.

appear.[1] It must be noted that, in high concentrations, methylene blue can act as an oxidant and can increase methemoglobinemia.

In patients who fail to respond to methylene blue, blood transfusions, exchange transfusions, hemodialysis, or possibly hyperbaric oxygen may be tried.[1,6] Glucose infusion may be helpful by increasing production of NADH and NADPH.[5] With such refractory cases, the possibility of G-6-PD deficiency, NADPH-methemoglobin reductase deficiency, and sulfhemoglobinemia should be considered.

Summary • This case report and review are intended to heighten awareness that acute toxic methemoglobinemia is an alarming intraoperative complication which can seldom be anticipated. A careful past history and family history are the only clinical tools which can be employed to establish a preoperative suspicion that methemoglobinemia might develop. Any events in the patient's history which suggest methemoglobinemia should receive serious consideration. Preoperative methemoglobin determinations are seldom helpful as toxic methemoglobinemia does not develop until after exposure to the toxic substance. One of the most frequently reported of these implicated substances is benzocaine, a commonly used lubricant for intubation.

When unrecognized and untreated, acute toxic methemoglobinemia may be lethal. Prompt recognition by determination of methemoglobin levels and prompt therapy with methylene blue are the essential elements of management.

References

1. Curry, S.: Methemoglobinemia, Ann. Emerg. Med. 11:214, 1982.
2. Jaffe, E.R.: Function of Red Blood Cells: Erythrocyte Pathobiology, Pp. 133-151, New York, Alan R. Liss, Inc. 1981.
3. Williams, W.J.; Beutler, E., et al: Hematology, New York, McGraw-Hill, Inc. 1977.
4. Wyngaarden, J.B. and Lloyd, H.S.: Cecil Textbook of Medicine, Philadelphia, W.B. Saunders Company, 1982.
5. Olson, M.L. and McEvoy, G.K.: Methemoglobinemia Induced by Local Anesthetics, Am. J. Hosp. Pharm. 38:89, 1981.
6. Smith, R.P. and Olson, M.V.: Drug-Induced Methemoglobinemia, Seminars in Hematology 10:253, 1973.
7. Ludwig, S.C.: Acute Toxic Methemoglobinemia Following Dental Analgesia, Ann. Emerg. Med. 10:265, 1981.
8. Donohue, W.J.: Acute Methemoglobinemia Induced by Topical Benzocaine and Lidocaine, Arch. Intern. Med. 140:1508, 1980.
9. McGuigan, M.A.: Benzocaine-Induced Methemoglobinemia, CMA J. 125:816, 1981.

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Early diagnosis of partially treated postsplenectomy pneumococcal sepsis

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ABSTRACT: Overwhelming postsplenectomy sepsis is a rare and devastating disease. The case is described of a 30-year-old man in whom the condition developed 11 years after splenectomy. Recent insights into the pathophysiology of this syndrome and recommendations for prevention and treatment are reviewed.

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Postsplenectomy sepsis was first reported in 1952 by King and Schumacker[1] who described five cases in 100 infants. Since that time many case reports and several series have been published documenting the prevalence of this condition in the pediatric population as well as its relative rarity among adults.[2-5] A large recent study from the Mayo Clinic[6] revealed two cases of fulminant sepsis among the 193 splenectomized patients. Other estimates have suggested an incidence of about 1%[4,7] which would represent 350 cases yearly since 35,000 splenectomies are performed in the United States annually.[8] Despite these statistics, overwhelming postsplenectomy sepsis has not been recognized nearly as frequently as might have been expected. Inasmuch as this devastating syndrome has a mortality rate of over 70%,[9] its early recognition and correct diagnosis are vital to proper treatment. This case report corroborates the continued occurrence of postsplenectomy sepsis in the adult population and reviews newer aspects of its pathophysiology, treatment and prophylaxis.

Case report ● A 30-year-old white man was transferred to Tampa General Hospital in septic shock. His past medical history was only positive for a splenectomy following a motorcycle accident 11 years earlier. He was well until the day prior to admission when he awoke with diffuse myalgias, arthralgias, headache, vomiting and diarrhea. He reported a slight fever, continued to feel poorly and presented to another hospital where he was found to have no obtainable blood pressure. He was treated with vigorous hydration and dopamine. Initial abnormal laboratory determinations revealed a left shift of white cells, prolonged prothrombin time and elevated fibrin split products. He was treated with heparin, gentamicin, cephalothin, clindamycin, chloramphenicol, and transferred to Tampa General Hospital.

On arrival the patient was awake, oriented and complaining of headache. Physical examination was remarkable for a blood pressure of 140/80 on 20 ugm/kg/min of dopamine, pulse of 140/min and temperature of 101.9 F. The only other positive physical finding was meningismus. Pertinent laboratory data included WBC 2800/mm^3 with 28% polys and 49% bands. The prothrombin time was 22.5 seconds (control 12), partial thromboplastin time 46 seconds, platelet count 159,000/mm^3 and fibrin split products >1:40. Lumbar puncture revealed 4000 WBCs with 95% polys. No organisms were seen on gram stain and the CIE was negative. Blood and CSF cultures were obtained but grew no organisms. A gram stain of the buffy coat of the patient's peripheral blood revealed several gram positive diplococci.

Penicillin G was begun in a dosage of 18 million units daily and other antibiotics were stopped. Heparin was continued, and hydrocortisone was given in stress-coverage dosage of 300 mg/day. The patient defervesced over the next three days and made an uneventful recovery. He was discharged on the 12th hospital day and in follow-up two weeks later was well. Pneumococcal vaccine was administered at that time.

Discussion • Proper treatment of overwhelming postsplenectomy sepsis depends on early recognition. In patients with a recent or remote history of splenectomy, sepsis should be suspected with any febrile illness. The most common causes of fulminant bacteremia in asplenic hosts include pneumococcus, meningococcus and Hemophilus influenza. Because of the very high level of bacteremia, 10^6 organisms/ml in asplenic patients as compared to 200 organisms/ml in patients with bacteremic pneumococcal pneumonia,[10] gram stains of peripheral blood or buffy coat may be helpful in identifying the causative organism before results of cultures are available. In this case, prior antibiotic use rendered all cultures sterile and the diagnosis was only established by inspection of a gram stain of the buffy coat. In addition to the bloodstream, the central nervous system is frequently involved. Lumbar puncture with gram stain and counterimmunoelectrophoresis of cerebrospinal fluid may similarly aid in early identification of the offending organism. Disseminated intravascular coagulation with or without hemorrhage into the adrenals and Waterhouse-Friderichsen syndrome may accompany fulminant pneumococcal sepsis.

The rationale for our use of steroids was two-fold. First, since a fair percentage of patients with postsplenectomy sepsis may have Waterhouse-Friderichsen syndrome,[11] it is necessary to provide steroids in stress-coverage doses to cover the possibility of adrenal hemorrhage and acute adrenal insufficiency. Second, although still quite controversial there is literature which suggests lowered mortality in patients given very large doses of steroids for septic shock.[12,13]

Several recent studies have helped to delineate the role of the spleen in host defense and have rendered more understandable the pathophysiology of postsplenectomy pneumococcal sepsis. The vast majority of RES activity against nonpathogenic ("rough," unencapsulated) pneumococci as well against virulent encapsulated pneumococci (if opsonizing antibody is present) occurs in the liver.[14] Bacteremia with virulent pneumococci in the absence of antibody fails to be cleared by the liver but is effectively cleared by the spleen. Lack of this major phagocytic "back-up" function of the spleen against pathogenic bacteria was demonstrated clearly in splenectomized guinea pigs in an elegant series of experiments by Brown et al at the NIH.[15] This absence is likely the primary immunologic defect leading to postsplenectomy pneumococcal sepsis. Brown and his colleagues utilized radiolabelled pneumococci and compared splenic and hepatic uptake of these organisms in immunized and nonimmunized animals. They demonstrated significant hepatic uptake of bacteria if the pneumococci were avirulent or there was opsonizing antibody present. In the absence of antibody, virulent pneumococci could only be cleared by the spleen. Therefore encapsulated organisms against which there is no opsonizing antibody fail to be cleared by the liver and must be removed by the spleen.

The spleen has been shown to have several other immune functions but these are less likely to be relevant in postsplenectomy pneumococcal sepsis. The spleen is important in normal antibody response to pneumococci[16] as well as other antigens. The spleen provides helper T cells but not all of the suppressor T cell function in the production of antibody to encapsulated organisms.

Splenectomy may no longer be viewed as an inconsequential procedure. Surgeons are recommending various modalities for preservation of splenic tissue following trauma.[12] Some patients who previously underwent splenectomy are often being treated with bedrest and transfusions while being followed by technetium scanning.[17] If a patient must undergo splenectomy, then vaccination with pneumococcal and meningococcal vaccines has been strongly advised. If splenectomy is elective, vaccination should be performed two to four weeks prior to the procedure as antibody response to vaccine is blunted in splenectomized patients.[15] Since many strains of pneumococcus are not covered by pneumococcal vaccine, additional use of penicillin prophylaxis has been recommended.[16,18,19] Physicians must also be cognizant of the rapidly fatal course that may ensue. A seriously ill asplenic patient must be quickly and carefully evaluated. Empirical therapy against encapsulated organisms should often be initiated.

Conclusion • Dickerman's review of the literature reveals only 16 cases of fulminant sepsis in adult patients who have undergone splenectomy following trauma. Of this number, only five survived. Since 1981 two additional case reports have appeared.[6,20]

This patient represents the 19th case and the seventh reported survivor of posttraumatic, postsplenectomy sepsis. The early diagnosis made by a gram stain of the buffy coat was of ultimate importance in rapid identification of the causative organism.

References

1. King, H. and Schumaker, H.B. Jr.: Splenic Studies I. Susceptibility to Infection After Splenectomy Performed in Infancy, Ann. Surg. 136:239-242, 1952.
2. Singer, D.B.: Postsplenectomy Sepsis. Perspectives in Pediatric Pathology 1:285-311, 1973.
3. Wilson, S.A. and Johnson, W.D. Jr.: Infection Complicating Surgical or Functional Splenectomy and Gastrectomy. In: Grieco, M.H., (ed): Infections in Abnormal Host, New York: Yorke, 1980, 848-865.
4. Krivit, W.; Giebink, G.S., and Leonard, A.: Overwhelming Postsplenectomy Infection, Surg. Clin. N. Amer. 59:223-233, 1979.
5. Francke, E. and Neu, H.: Postsplenectomy Infection, Surg. Clin. N. Amer. 61:135-155, 1981.
6. Schwartz, P.E.; Steriott, S.; Mucha, P., et al: Postsplenectomy Sepsis and Mortality in Adults, JAMA 248:2279-2283, 1982.
7. Dickerman, J.D.: Traumatic Asplenia in Adults, Arch. Surg. 116:361-363, 1981.
8. Dickerman, J.D.: Splenectomy and Sepsis: A Warning, Pediatrics 63:938-941, 1979.
9. Gopal, V. and Bisno, A.: Fulminant Pneumococcal Infections in "Normal" Asplenic Hosts, Arch. Int. Med. 137:1526-1530, 1977.
10. Torres, J. and Bisno, A.: Hyposplenism and Pneumococcemia, Amer. J. Med. 55:851-855, 1973.
11. Sherman, R.: Rationale for and Methods of Splenic Preservation Following Trauma, Surg. Clin. N. Amer. 61:127-134, 1981.
12. Sheagren, J.N.: Septic Shock and Corticosteroids, N. England J.M. 305:456-457, 1981.
13. Schumer, W.: Steroids in Treatment of Clinical Septic Shock, Ann. Surg. 178:333-339, 1976.
14. Hosea, S.W.; Brown, E.J.; Hamburger, M.I., et al: Opsonic Requirements for Intravascular Clearance after Splenectomy, N. England J.M. 304:245-250, 1981.
15. Brown, E.J.; Hosea, S.W., and Frank, M.M.: Role of Spleen in Experimental Pneumococcal Bacteremia, J. Clin. Invest. 67:975-982, 1981.
16. Ammann, A.J. and Diamond, L.K.: Indication for Pneumococcal Vaccine, N. England J.M. 299:778, 1978.
17. Pearson, H.: Splenectomy: Its Risks and Roles, Hosp. Prac. 15:85-94, 1980.
18. Dickerman, J.D.; Bolton, E.; Coil, J.A., et al: Protective Effect of Prophylactic Penicillin on Splenectomized Mice Exposed to Aerosilized Suspension of Type III S. Pneumoniae, Blood 53:498-503, 1979.
19. Dickerman, J.D.: Bacterial Infection and Asplenic Host: Review, J. Trauma 16:662-668, 1976.
20. Parker, C.: Septic Shock in Young Splenectomized Man, Amer. J. Med. 74:129-143, 1983.

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SPECIAL ARTICLE

Osler's professorships and their impact on his family

George T. Harrell, M.D.

Election to Alpha Omega Alpha is recognition of superior scholarship and dedication to medicine. It is not achieved without support by wives and families. It will affect career decisions you are now making. Historically, in the range of 8% of medical school graduates elect academic careers. The probability is that most will be honor society members. Your election ultimately may well influence how you spend your professional life. Wives and children of students have little idea of a doctor's future life, especially if he is academically inclined.

Let us look at the teaching career of the most charismatic professor at the turn of the century, William Osler. His influence, through the students he taught, on medical education and the care of patients has persisted long after his death. The pressures on the family felt today by a successful career are much the same as then, but have increased in intensity as society and medicine itself have changed through the years.

Osler as a child lived on the edge of the frontier wilderness in Canada. His father was an Anglican missionary with minimal financial support. Life was hard on the nine children, most of whom sought an easier and more secure life as adults. Osler's older brothers were financially very successful in their careers in law, business and finance.

The Author
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After he finished medical school at McGill, Osler spent two years studying overseas. When he returned to Montreal penniless at the age 25, he was offered a position teaching physiology and pathology in the medical school. Teachers got no salary, but received fees directly from students. During his ten years in Canada, these fees were in the range of $1,200 annually. All the teachers practiced and Osler collected less than half the amount he received from students for occasional consultations. In today's dollars, his total income was about $12-15,000 per year.[1] He was deeply engrossed in his teaching and spent his own money to buy microscopes for his students' use. He was doing autopsies, often making his own slides, reading voraciously, writing and speaking widely. His knowledge of natural history, which began as a schoolboy in the study of microscopic life in fresh water ponds and of animal diseases such as trichinosis, led to his appointment simultaneously as Professor of Physiology in the Veterinary College of Montreal. Whether he received separate fees for that teaching was not discovered. He was too busy and had too little income to consider marriage. He rented simple rooms and at times lived in the home of a cousin, Marian Francis.[2]

Osler's reputation, based on his teaching and especially his writing, grew. His paper presented at Oxford heard by a young Philadelphia surgeon, Samuel Gross, led to an invitation by the University of Pennsylvania to fill the Chair of Clinical Medicine. He was 35 and had to borrow $1,000 to move. All the teachers supported themselves through patient fees. Most did general practice with regular afternoon office hours and did home visits. Osler rented a house, set up a simple office there and saw patients only by appointment. He rode the streetcar to the hospital and to consultations. He made early morning

rounds in the hospital or Outpatient Department, then ate on the ward the lunch he had brought. In the afternoon, he would do autopsies with students. He improvised a clinical laboratory under the ampitheatre where his own microscope was the only one in University Hospital.

Osler's mother hoped he would marry. Rumors of romantic interests filtered back to Canada where relatives kept track of them, denied all and hoped he would keep clear of entanglements. He did. He did not entertain and ate his dinners at a club. A limited social life revolved around the young surgeon, Dr. Gross, and his wife, Grace, whose house was near the one Osler rented. He would often stop there for tea when many young people gathered. Grace served as hostess for her famous father-in-law who was a widower. Osler frequently was included in dinners for prominent professional people many of whom came from abroad. How Gross met his younger wife is a very romantic story. She was a Boston society belle, the great granddaughter of Paul Revere.[3]

Osler stayed in Philadelphia only five years. His reputation as a teacher, clinician and author led to the call at age 39 by The Johns Hopkins University to become Chief of the Medical Department of the Hospital. Just before he left Pennsylvania, his surgeon friend caught a severe pneumonia and asked Osler to look out for his wife should he die. By then, Osler could have afforded to marry. Fees from practice now exceeded those from students and his income in current dollars was in the range of $30,000 annually. He only saw one to two patients per day or five per week. Some fees now were large, as much as $600 or about $400 today. He took long summer vacations in Canada or abroad, a habit he continued with his family after he married. The purchase of old books, a life-long passion, was taking much of his money. They were both medical and classical volumes to which he had been introduced as a theology student in college before he changed to medicine.

It should be recognized that it was his inner drive to excel, not practice nor academic pressures, that pushed him to become the admired teacher and clinician. His only research was descriptive and not laboratory or bench in nature as is expected today. Up to this time he had no administrative duties such as head of a department. His practice was not organized and he did not appear interested in achieving a substantial income from it. The teaching effort was directed at personal contact with students in the hospital and much of it was outside of scheduled exercises. In his writing, the idea of a text based on his own autopsies already had formed and he accepted an advance from a publisher against future royalties to begin writing it.

Leaving Philadelphia, Osler moved into the interns' quarters of the hospital on his arrival in Baltimore. He rented a house for a few months, but moved back into the hospital to write the textbook in his bedroom. Up to this time, everything he had written was done in longhand. He had for the first time a salary, $5,000, which never changed and a secretary.

Osler and his friend, the widow in Philadelphia, kept in touch. He must have proposed to her, but she told him to "stick to his last" and finish the book. After three years' work, it was published and he threw the first copy in her lap and asked what she was going to do about him. They were married the same year and his life drastically changed. He bought his first house and began to entertain there with afternoon "at homes" or teas. The medical school finally opened the next year. His original appointment had not included an academic title and the first teaching done was to house officers, visiting students and practitioners. The growing collection of books was placed in a library and selected students, called "latch-keyers," were given access to the house so they could use them. Groups of students were invited on Saturday nights over beer, pretzels or sandwiches to see books and discuss them. His ward clerks would be invited to dinner. Teaching began at eight in the morning and concluded shortly after noon when he returned home for lunch and a rest.

For the first time, he began regular office hours from two to four-thirty. Practice greatly increased, whether as a response to the phenomenally successful text or to the organization by his wife of life in the home where he saw patients, is difficult to say. She had lived with successful surgeons and had brought her butler and maid from Philadelphia. Grace arranged the social affairs with many large dinner parties as well as teas. Afterwards, Osler would disappear to read or do consultations leaving the entertaining of guests to her. Osler saw five patients a day, five days a week, only by appointment and only during the school year. He was doing consultations in homes and other hospitals, using a hansom cab, in Baltimore as well as in other cities including some in Canada. The family had no phone or carriage and Osler still rode the streetcar to the hospital. He would occasionally hire a special train for out-of-town consultations. Fees increased, income rose sharply and reached a peak in 1903 of nearly $400,000 in current dollars, a figure probably not attainable today by a clinical professor of medicine. Though he did admit occasional private patients to Hopkins and did consultations there, he apparently never charged a patient in that hospital. He wrote that a doctor needs a wife to look after his house and rear his children but that he should keep affairs related to practice to himself. Osler brought his godson and namesake, William W. Francis, the child of his cousin in Canada, to Baltimore and put him through medical school.

Soon after their marriage, Mrs. Osler became pregnant. A boy was born at home but developed

jaundice and died in five days. Both parents were depressed by the outcome since they had looked forward to the child. In the light of current knowledge, there must have been an Rh problem, a disease unknown at the time but which would have required an unreported pregnancy during her first marriage. Information obtained from her family revealed she had indeed had a miscarriage.

Three years later a second pregnancy resulted in another boy, Revere, who was the joy of his parents throughout his life and they showered affection on him.[4] Both parents must have recognized this pregnancy would be her last since she was 42 and Osler was 46 years old. By age three the boy, assisted by his father, was happily driving nails into the floor and furniture. Osler read to him from the classics and cultivated a love of books which developed gradually. At age nine during a trip to Canada, the boy became fascinated with fishing, which remained his greatest life-long interest. His father gave him a first edition of Izaak Walton. His parents wanted him educated in England. Grace became increasingly concerned that the pressure of consultative practice with its extensive traveling was killing her husband. While on a speaking trip to Oxford, Osler was offered the Regius Professorship of Medicine there. Grace cabled him to accept at once, which he did.

Osler was now nearly 56, Grace 51 and Revere 11. They looked forward to a less hectic life on a British University campus with more time together as a family. Mrs. Osler had an independent income from her first husband's estate which they thought would be enough to support them in a simple lifestyle. She sold her house in Philadelphia and they bought one in Oxford which became known as "The Open Arms." Teaching was much less demanding than in America and was confined to preclinical subjects. The Regius Professor was required to give only a few lectures a year since the students took their clinical work in hosptials in other cities, usually London. Practice was less than in America, but patients immediately appeared to be seen in the home. Consultations throughout Britian promptly came. Fees were larger and income remained higher than expected. The Oxford salary was only £400 per year.

Entertaining of university people, visitors from abroad and students greatly increased. Osler would bring unannounced guests for dinner or to stay in the house. Sunday afternoon teas would have as many as 50 people with a number staying for buffet dinner. Girls were included since Mrs. Osler liked to have them around to meet American or Canadian students. The son was not a studious type and preferred to fish, do cabinet work or to etch. His father tried unsuccessfully to interest him in science and concluded the boy would become an architect or artist. Osler kept Revere involved in the purchase of old books and the development of the library which ultimately would go to McGill. His mother tried to get her shy son interested in several Canadian girls who were students in Oxford. The family bought their first car, but only a chauffeur drove it. Osler was made a baronet and Grace became Lady Osler.

World War I broke out and altered their lives. Sir William became involved with military hospitals and Lady Osler organized extensive local ladies programs for refugees and to make supplies. Revere was admitted to college where he felt tremendous peer pressure to join the Army. His parents and the family in Canada urged him to continue his education. When he threatened to volunteer, a commission quickly was arranged with the McGill base hospital unit which was soon to come to England. Revere wanted action, transferred to the artillery and was killed in Flanders at age 21. In spite of his shy, retiring nature, he had not let his parents run his life.

Both parents were crushed by their son's death. Sir William lost weight, cried in bed, aged noticeably and eventually caught pneumonia from which he died at age 70. He and Lady Osler endowed the Tudor and Stuart Club in Revere's memory at the Johns Hopkins liberal arts campus to promote love of English literature. She continued the tradition of "The Open Arms" and kept up regular correspondence with old students and her family. A young Canadian girl who had dated Revere stayed in the home for a time and was bequeathed Grace's engagement ring. Revere's books were sent to Baltimore. The organizing and cataloging of Sir William's library finally was completed under her supervision by the godson who lived in the home with his wife and child. He would take the books to McGill and become the Curator of the Osler Library until his death. A few days after the delivery of the first packing boxes for the shipment to Canada, Lady Osler had a fatal stroke. She left "The Open Arms" to the university to be the home of future Regius professors. She had herself been a superb professor's wife.

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References

1. Harrell, G.T.: Osler's Practice, Bull. Hist. Med. 47:545-568, 1973.
2. Harrell, G.T.: The Osler Family, JAMA 248:203-209, 1982.
3. Harrell, G.T.: Lady Osler, Bull. Hist. Med. 53:81-99, 1979.
4. Harrell, G.T.: The Osler's Son - Revere, Bull. Hist. Med. 54:561-571, 1980.

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NOTES & NEWS

$1.5 million federal grant awarded to FMHI at USF

A five-year, $1.5 million federal grant to conduct research, training and consultation activities for seriously emotionally disturbed children has recently been awarded to the Florida Mental Health Institute at the University of South Florida, according to Governor Bob Graham.

FMHI's grant, which amounts to $300,000 for the first year, was one of only two awarded in a national competition to establish a "Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children" by the National Institutes of Handicapped Research and Mental Health. A second grant for $200,000 was made to the Regional Research Institute at Portland State University.

To address the national problem of the underserved population of severely emotionally disturbed children, the new Center, under the direction of Dr. Robert M. Friedman, will conduct an integrated set of research, training and consultation activities designed to improve the children's mental health system.

According to Dr. Friedman, the President's Commission on Mental Health estimates there are three million seriously emotionally disturbed children in the United States, or approximately 5% of the child population. He added that while the mental health community varies in its definitions and treatment approaches, it is in agreement that the severely emotionally disturbed child population is greatly underserved.

"Children have been one of the most neglected populations in the mental health field," he said. "They have been both underserved and ineffectively served. The establishment of this Research and Training Center offers an opportunity to assist states in the development and implementation of more effective systems for preventing and treating emotional problems in children.

"The major challenge that we face in children's mental health is how to provide the prevention and early intervention services that will ultimately have the greatest impact on the prevalence of emotional disturbance in children, while still providing the needed services for children who are already demonstrating serious and persistent problems."

Since seriously emotionally disturbed children typically have miltiple problems requiring a variety of services, the Center will focus on the mental health system, education, vocational training, and the child welfare and juvenile justice systems.

The research activities will involve four interrelated studies. The first study will utilize a longitudinal research approach over a four-year period to examine the characteristics of seriously disturbed children, the services they receive, the changes that take place over time, and the ultimate outcome of the services. The study will include 960 subjects initally between the ages of nine and 17 from four different states.

The second study will involve a national survey of services provided to emotionally disturbed children within the educational, mental health, vocational rehabilitation, juvenile justice and child welfare systems. The study will also involve the identification of exemplary programs and systems of service across the country.

The third study will be an integrative and evaluative analysis of research on the prevalence of emotional disturbance in children. The fourth component of the research program will seek to develop and test standards for services for emotionally disturbed children that can guide policy and program development.

The Center will also conduct a broad range of training and consultation activities. These will include workshops in different regions of the country on important policy topics related to children's mental health services, workshops to help agencies replicate programs that are identified as exemplary, and consultation to states in strengthening their overall system of services for emotionally disturbed children.

The Center will be operated as a component of the Department of Epidemiology and Policy Analysis at FMHI. In addition, the Center will utilize faculty from other departments at FMHI and USF. The Center will also work closely with a distinguished group of consultants from across the country, and a National Advisory Board.

The advisory board includes Colleen Bevis of Tampa; Rep. Mary Figg of Lutz; Dr. Herbert Quay of the University of Miami; Diana Wells of the Florida Department of Education; Susan Yelton of the Florida

Department of Health and Rehabilitative Services; and Chris Zeigler of the Florida Council for Community Mental Health.

Dr. Peek honored by Blue Cross and Blue Shield

Eugene G. Peek Jr., M.D. of Ocala was recently honored by Blue Cross and Blue Shield of Florida, Inc. after 18 years of service as a member of the Board of Directors. The Board of Directors of Blue Cross and Blue Shield of Florida, Inc. awarded a bronze plaque to Dr. Peek which expressed appreciation for his numerous contributions, dedicated support, and "...deep concern for, and commitment to, the health and welfare of the people of the State of Florida." Dr. Peek continues to serve as a member of the Professional Services Advisory Committee to the Board of Directors.

Dr. Dockery accepts Southern Medical Association Chairmanship


Dr. Dockery

J. Lee Dockery, M.D., Associate Dean of the University of Florida's College of Medicine, was installed as chairman of the Council of the Southern Medical Association at its 78th annual scientific assembly in New Orleans on November 6.

Dr. Dockery, who also is a professor of obstetrics and gynecology at UF, will serve a year as head of the association's governing council. The group includes a councilor from each of 16 southern states and the District of Columbia, plus other elected officers. More than 43,000 physicians hold membership in the organization, founded over 75 years ago to foster development of scientific medicine.

Dr. Dockery, who has been with UF's medical college since 1975, is Immediate Past President of the Florida Medical Association. He currently is President-Elect of the Florida Obstetric and Gynecologic Society and a member of the American Medical Association's Council on Medical Education. Within his specialty, he is a Fellow of the American College of Obstetricians and Gynecologists, a Diplomat of the American Board of Obstetricians and Gynecologists, and of the Association of Professors of OB-GYN.

Dr. Copeland wins research award at Southern Medical Association


Dr. Copeland

At the November convention, Edward M. Copeland III, M.D., professor and chairman of the Department of Surgery at UF's College of Medicine, received the 1984 Seale Harris Medal for outstanding accomplishment in the broad field of metabolism and endocrinology. Dr. Copeland was cited specifically for his notable contributions to clinical investigation of nutritional support for surgical and cancer patients.

Dr. Copeland joined the UF medical faculty in 1982, coming from the University of Texas M.D. Anderson Hospital in Houston where he was a professor of surgery for 10 years. His professional memberships include the American Board of Surgery, the American College of Surgeons, the American Society for Clinical Nutrition, the American Society for Parenteral and Enteral Nutrition, the American Society of Clinical Oncology and The American Surgical Association.

International flair at USF

The University of South Florida College of Medicine under the direction of Dean Andor Szentivanyi has begun a series of on-going International Symposia in the Biomedical Sciences. Each symposium is designed around the topic that has world interest and is presented by a department of the Biomedical Sciences here at the College of Medicine. Each symposium has invited speakers from around the world who are noted authorities in their respective fields.

The first symposium was entitled "Viruses, Immunity and Immunodeficiency" and was held in April 1984. The program was presented by the Department of Medical Microbiology and included a national and international faculty. Topics ranged from viruses and their relationship to cancer, to genetics and autoimmunity, to the acquired immunodeficiency syndrome. In addition, 24 abstracts of current research with viruses and immunity were presented.

Future symposia are scheduled to begin again in January 1985. Themes for these symposia are as follows: "The Biology of Endotoxins," "Clinical Virology Symposium," and "International Cancer Symposium."

Information regarding any of the symposia can be obtained from the Office of Continuing Medical Education, University of South Florida College of Medicine, (813) 974-4296.

DEAN'S MESSAGE

The changing face of financial aid for medical schools

The results of the national Medical Student Graduation Questionnaire for the class of 1984 recently arrived at this college. The questionnaire records students' retrospective responses to questions concerning their medical education, e.g. curriculum, postgraduate training and financial burdens. The average debt for students from all medical schools was approximately $25,000, accumulated during four years of medical school. The tuition for medical students ranges from no tuition at some schools to a high of $25,000 per year for certain private schools.

As a state supported college of medicine, we are fortunate to have relatively low tuition expenses; however, tuition at this college of medicine, while relatively low when compared to other schools accounts for a small percentage of the cost of medical education and living expense for our students. Unfortunately, our students may be perceived to have a low debt and a low overall need for student loans or scholarships. This is not the case. The previously mentioned Medical Student Graduate Questionnaire indicates that the mean overall debt for our students, after four years of medical school, is approximately $22,000, very close to the national average.

Several factors have led to the increase in indebtedness of our students, and others throughout the country. These factors are based upon the current economic climate, state and federal fiscal policy, and local conditions, all of which contribute to increased debt. The tuition for professional students at state universities in Florida is rapidly approaching $3,000 per year and the cost of living has increased in most metropolitan areas. At the federal level, policies which have been in effect over the last few years have made it more difficult for professional and graduate students to borrow money under federally subsidized programs. Successful attempts have been made to eliminate sources of funds which were available for students with large financial need. The Health Professions Student Loan Program was placed in jeopardy several years ago by media and congressional publicity given to the large default rate by those already practicing medicine. While this College has an extremely low default rate compared to other schools, we have suffered the consequences of cutbacks in this program and cannot count on these funds for our most needy students. The Guaranteed Student Loan Program has not kept pace with the increase in cost. The yearly amount and the aggregate borrowing limit, the total which may be borrowed by a student for both undergraduate and graduate school, have not increased. It is estimated that nationwide, over the last eight years, costs at professional schools have risen an average of 14% while the borrowing limit for the guaranteed student loans has remained static; students are not able to borrow annual amounts of greater than $5,000 per year. These loans are attractive to students in that they are made at rates substantially lower than commercial loans. Newer loans which have received attention, are underwritten by the government but contain interest rates which vary as do Adjustable Rate Mortgages. In addition, interest is not deferred; rather, these loans begin accruing interest from the day of the students' receipt, with interest compounding along with principal.

As a relatively young college of medicine, we are unable to fall back on other sources of funding which will make up for the deficits of our students. It is therefore easy to calculate that even though our tuition is relatively low our students still incur debts which are close to the national mean. There is fear that in the future, in order to decrease the federal deficit, student financial assistance will be a likely target for cuts in government spending. This occurrence would have terrible impact upon our students as well as those throughout the country, as it would occur at a time when expenses are increasing and most sources of funding are shrinking.

We at this college are thankful for the scholarships and endowments we have received to date and are encouraged by the response to the American Medical Association Education and Research Fund Program (AMA-ERF), as well as those funds which have been granted to us by county medical societies throughout the state of Florida. Our fear is that this may not be enough for the future. We encourage those who have an interest in medical education to support all medical schools throughout the nation. We urge that you write to Terrell H. Bell, Secretary of Education, US Department of Education, 400 Maryland Avenue SW, Washington, DC 20202, requesting his support to increase the borrowing limits for Guaranteed Student Loans by exercising his authority under the Higher Education Act and we encourage you to urge his support for future funding of professional education.

Alan I. Leibowitz, M.D.
Associate Dean for Student Affairs
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Deputy Dean
University of South Florida
College of Medicine

WORTH REPEATING

Dishonesty in medicine

In a recent case of fraud at Harvard Medical School, a physician-researcher brazenly fabricated data. As a postscript to the affair, another Harvard researcher said, "The man could have gently faked his way through a lifetime of research and have been greatly honored. We all know scientists like that."[1]

This event refocused international attention on deceit in science, but outright faking of research findings is only part of the problem. Less obvious kinds of dishonesty are much more common. Although we recognize that dishonesty is sometimes a matter of interpretation, we still believe it to be endemic in the medical literature, in medical school and postgraduate training, and in the way we practice medicine.

Dishonesty in the medical literature, aside from the type already mentioned, can take several forms.[2-4] Of these, only one — clear-cut plagiarism — is uniformly condemned. The remainder are harder to detect and, even if discovered, are often condoned. For example, authors may deliberately discard undesired data or simply design their studies to yield only the desired results. The may rig references, preferentially citing their own papers while ignoring relevant reports by rivals. They may steal from themselves — autoplagiarism — and submit the same material, disguised as different articles, to a number of journals. They may not take responsibility for all elements of a paper, or they may permit their names to be listed as authors although they have made no real contribution to the work reported.

Refereeing of medical writing can generate additional abuses.[2,3] A referee with vested interest in a particluar field of research or clinical medicine may decide for or against a manuscript depending on whether it supports or contradicts the tenets he holds. He may base his decision on who did the work and where. Worst of all, he may pilfer ideas from articles he rejects.

Dishonesty in the medical school and postgraduate training generally hides under the guise of professional etiquette. It shows up, however, as sycophancy, silence, "one-upsmanship," grades, and letters of recommendation.

Sycophancy, usually called "brown-nosing" or "apple-polishing," flourishes in academia. It is particularly noticeable on teaching rounds, where the instructor and student say and do what each presumes the other wants rather than what is needed. Both can leave these sessions with ego intact — and ignorance undented.

Silence is the response of many students, house officers, and experienced physicians to a colleague whom they know or suspect to be emotionally disturbed, a substance abuser, or just plain incompetent. Their reluctance to get involved is equally deplorable when they know or suspect an associate to be cheating on an exam or lying about a case.

One-upsmanship becomes dishonest when teachers and students alike intentionally spew forth untraceable information: "A group in Scandinavia first described that treatment some time ago in one of the clinical journals," or "I've seen several cases that prove my point."

Grades often reflect more a vote for the person's charisma than a rating of academic accomplishments. No one ever fails, and almost everyone is "very good" or "exceptional."[5]

Letters of recommendation rarely tell the whole truth. They typically dwell only on the positives and usually attempt to make mediocrity appear "above average."[5,6]

Dishonesty in medical practice can be difficult to spot because the manifestations characteristically conform to the "accepted standard of medical care in the community." Their common denominator is the shirking of responsibility, which compromises the perpetrator's integrity. The consequent buck-passing results in a host of ill-advised activities, including excessive consultations, inappropriate testing, undocumented diagnoses, overprescribing of medications, uncalled-for operations, needlessly prolonged hospitalizations, and unnecessary office visits. It also encourages the physician to conceal complications,[7] expurgating his medical records to prevent peer review or lawsuits.

Other acts of medical dishonesty deserve comment. Fraudulent claims relating to Medicare and Medicaid reimbursement continue to be uncovered. Hospitalizing patients solely because their insurance will not pay for a work-up in the office has been common. Certain physicians, attracted by high remuneration and perhaps by the desire for public recognition, serve as "expert witnesses" even though they are unqualified for the role.[8]

What causes dishonesty in medicine? Two synergistic factors are paramount. One is a background of intense competition. We compete to get into medical school; we compete to stay there; we compete for the intership and residency of our choice; and thereafter we compete for patients, research grants, or whatever. The other factor is human frailty — in particular, ignorance, greed, fear of being wrong, and the need for aggrandizement. Patients frequently foster our frailties by conferring god-like qualities on us. In return, we prevaricate to protect this image for them as well as for our colleagues and ourselves.

Is there a cure? There is, but only insofar as we are willing to be role models of integrity and honesty for each other. Condoning or forgiving dishonesty of any type is itself dishonest — and, in medicine, can be tragic.

Herbert L. Fred, M.D.
and Patricia Robie
Houston, Texas

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References

1. Knox, R.: The Harvard Fraud Case: Where Does the Problem Lie? JAMA 249:1797-1807, 1983.
2. Manwell, C. and Baker, C.M.A.: Honesty in Science: A Partial Test of Sociobiological Model of the Social Structure of Science, Search 12:151-160, 1981.
3. Ingelfinger, F.J.: Peer Review in Biomedical Publication, Am. J. Med. 56:686-692, 1974.
4. Relman, A.S.: Lessons From the Darsee Affair (ed.), N. Engl. J. Med. 308:1415-1417, 1983.
5. Friedman, R.B.: Fantasy Land, N. Engl. J. Med. 308:651-653, 1983.
6. Yager, J.; Strauss, G.D. and Tardiff, K.: The Quality of Deans' Letters From Medical Schools, J. Med. Educ. 59:471-478, 1984.
7. Goldwyn, R.M.: Reporting or Hiding a Complication (ed.), Plast. Reconstr. Surg. 71:843-844, 1983.
8. Brent, R.L.: The Irresponsible Expert Witness: A Failure of Biomedical Graduate Education and Professional Accountability, Pediatrics 70:754-762, 1982.

CORRESPONDENCE

Dear Editor: I would like to congratulate you on the excellent special issue of *The Journal of the Florida Medical Association*, September 1984. It is certainly a comprehensive review of public health in Florida.

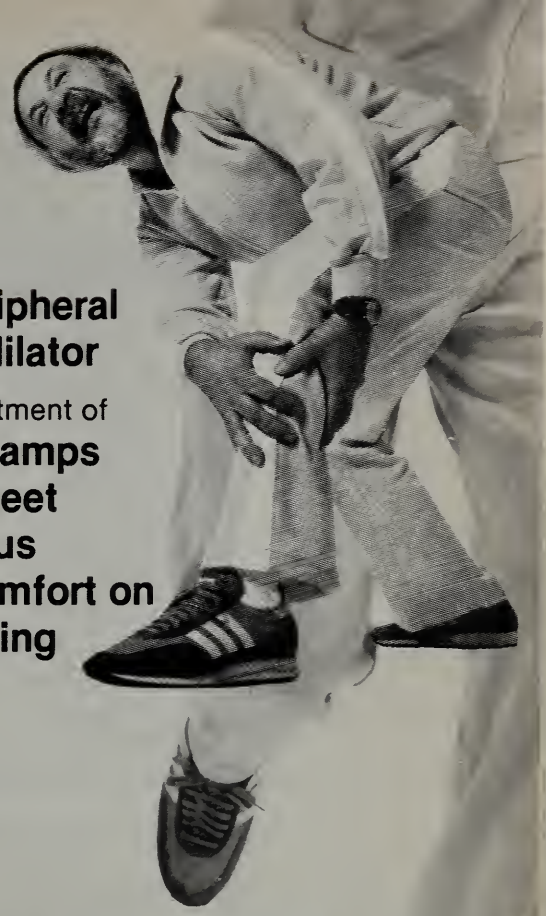
In particular, Dr. Carl Brumback's article, "A Response" points out many of the problems and obstacles that we have in the public health field. He points out that prevention is hard to sell, many professionals are more interested in treatment than prevention, and many professionals are not aware of what public health does.

Everyone agrees that preventive medicine is cheaper than "crisis" medicine, and both the lay public and the medical professionals praise the concept of preventive medicine, but they do little about it.

Perhaps with improved communication between all parties, (as Dr. Brumback has emphasized), and more publicity on this subject, we will attract more trained professionals, get patients to engage in more preventive measures for their health, and get a higher priority for preventive medicine.

Dr. Brumback is to be congratulated for bringing this matter to our attention.

N. Harry Carpenter, M.D.
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Auxiliary Liaison Editor — **Mrs. Walter (Isabella) Laude**

Fall Conference 1984

Members of the Florida Medical Association Auxiliary from throughout the state converged on Sandpiper Bay, Port St. Lucie, September 18-20 for the 1984 Fall Conference. An intense three days of workshops, seminars, and meetings emphasized this year's theme, "AUXILIARY IN ACTION."

"Take One" featured the secretary of the American Medical Association Auxiliary, Mrs. Mylie (Pat) Durham of Houston, Texas. Explaining the Auxiliary as a federation of local, state and national organizations, Mrs. Durham stressed the value and importance of the common bond uniting us for common goals.

With the vast changes taking place in the health care delivery system, every physician's spouse is needed to extend the work of the physician into the community and to help educate citizens about current problems such as drunk driving and child abuse. One voice can be heard, but 80,000 voices produce a crescendo of sound difficult to ignore. The influence of our organization is being felt in many places, and in recent years our own national presidents have been invited to the White House.

Using an immense portfolio of program aids and materials available to Auxilians through the AMA-Auxiliary's *Project Bank*, Mrs. Durham oriented the Florida Auxilians to some of the numerous projects which have been conducted by counties and which are listed in the *Project Bank*. She offered her assistance to any county and encouraged all to avail themselves of these opportunities. Another valuable resource is the *People Bank* which is a group of advisors and speakers willing to lend their skills to component auxiliaries for various projects and topics.

"Take Two" focused on legislation. Mrs. Stephen (Carolyn) Spore, FMA-A Legislative Chairman, presented an informative and dynamic review of important legislative issues affecting medicine. Included was a bill designed by Senator Dempsey Barron which enacted a study commission to consider the medical liability problem. It is hoped that this will help physicians and the public with the liability crisis by providing suggestions for relief from the high cost of liability insurance.

Frank C. Coleman, M.D., President of the Florida Medical Association, provided information on Constitutional Amendment Nine and outlined a number of questions most likely to be asked of Auxilians.

State Chairman on Aging, Mrs. Fred P. (Anne) Swing, introduced the MEDI-FILE — a wallet card for listing medications provided by the Florida Medical Association and Auxiliary. The card is free of charge to Florida senior citizens from their physicians in an effort to help prevent medication misuse, undesirable drug interactions, and as a memory aid for medications.

"Take Three" centered the spotlight on Marie Zeller, a nurse and psychological consultant from Jacksonville. Ms. Zeller conducted an in-depth seminar on "Assertive Leadership and Communication," giving helpful hints to Auxilians on the most effective means for achieving objectives, meaningful relationships, and maintaining self-respect.

AUXILIARY IN ACTION concluded the demanding educational and planning sessions with a successful silent auction which netted over $1500 for International Health, Mrs. Ben M. (Barbara) Crowder, Chairman. The fund for AMA-ERF was also enriched with over $500 through the efforts of ERF Chairman, Mrs. Guy T. (Joan) Selander.

Fall Conference 1984 was a time for sharing and learning everything you always wanted to know about your national and state committees and projects. With renewed vigor and enthusiasm, Auxilians dispersed to their home counties to implement their ideas and proposals for an AUXILIARY IN ACTION.

Mrs. C. Brooks (Ruth) Henderson
State Orientation Chairman
Ocala

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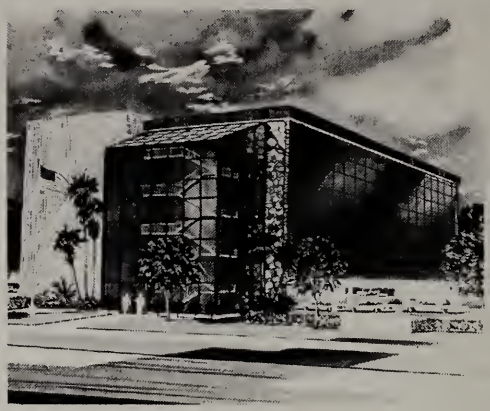
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PRESIDENT'S PAGE

FMA efforts for tort reform renewed



Although the Florida Supreme Court's decision to remove Amendment 9 from the ballot weighs heavily in our thoughts, the outlook for a solution to the professional liability problem can provide us with a high degree of optimism. Many positive accomplishments were gained from our constitutional initiative campaign, not the least of which are the public statements from Governor Bob Graham and legislative leaders that solving the malpractice problem should be a priority in the 1985 Legislative Session. With these statements, as well as an offer from the Florida Bar to work with us, I believe our ultimate success in achieving an effective and equitable solution will be significantly enhanced.

In November, Governor Graham appointed an 18-member Task Force on Medical Malpractice with the expressed intent of studying a number of plans and formulating recommendations to solve the problems of high insurance rates for physicians and the deficiencies in the tort system. "Access to quality care is a right of all Floridians," Governor Graham said. "Increasing costs threaten to erode that right and a key element is the rising cost of medical malpractice insurance. Both by directly increasing the cost of practicing medicine, and by indirectly encouraging the expensive practice of defensive medicine, malpractice insurance rates are affecting all of us. To protect our citizens from runaway health costs, Florida must address this issue fairly, comprehensively and promptly." I am certain this measure of support will prove to be a major factor in helping to bring about the needed reforms.

In addition, many of our elected representatives in both the House and Senate have pledged to work actively with the FMA. The 1985 Florida Legislature will include three physician members, Senator William G. "Doc" Myers, M.D., Bernard Kimmel, M.D., and David Thomas, M.D., newly elected members of the House of Representatives. Representative Betty Metcalf, wife of George W. Metcalf, M.D., will also return to the House. Your political action committee's support of candidates who can provide the leadership necessary for our efforts to be successful, yielded very favorable results in the November elections. With the assistance of these legislators, we have an excellent prospect for the passage of legislative measures aimed at the professional liability problem.

A high public awareness of the existence and seriousness of the problem is also a very visible result of our campaign. Records were set in both the number of signed petitions collected and the time it took to collect them. The media coverage we received was invaluable and was one of the major factors in calling attention to the problem and although the media was generally unsupportive of Amendment 9, editorial writers around the state stressed support for statutory reform. Organized medicine's concerns in Florida received national attention through the media and established for us an avenue of access to the public we were previously unable to secure.

One achievement we as physicians should be particularly proud of is our demonstration of unity through extensive participation in efforts to reduce health care costs and preserve the quality and availability of medical care. Many physicians expended

time and energy to the Reason '84 Speakers Bureau, the petition signature drive and many other aspects of the campaign. While providing the financial support necessary for this type of effort, we also signed pledges to pass the savings resulting from the effects of the proposed amendment on to our patients, representing a tangible commitment from Florida's House of Medicine. The American Medical Association and several other state medical associations also rallied behind us during the campaign and remain committed in their support for future efforts. They understand that the professional liability crisis in Florida is a harbinger of the professional liability peril that physicians in every state face currently or in the immediate future.

We also benefit in our future efforts from the extensive research and documentation resulting from Reason '84. The study by M.G. Lewis Econometrics, Inc., which showed a possible $14 billion dollar reduction in health care costs within five years of Amendment 9's passage, brought together a multitude of substantial information reflecting the seriousness of the problem. It also showed that significant results following a resolution of the professional liability problem are attainable and crucially needed. Public opinion polls and strategies which were planned for the campaign will also be helpful in formulating and directing our continued efforts.

Amendment 9 was the most successful constitutional initiative campaign in Florida's history. The 630,000 signatures of registered Florida voters sent a loud and clear message to our state executive and legislative leadership that meaningful tort reform in Florida must occur to resolve the malpractice crisis.

Your Board of Governors, at its meeting held on October 10, directed that the Association continue to exert every effort to permanently resolve the professional liability problem. As part of that effort, the Board of Governors authorized me to appoint a Blue Ribbon Panel comprised of the Council on Legislation and other prominent individuals to define and recommend a statement of policy for future tort reform efforts. Members of the Panel include: Chesterfield Smith, Esq., Miami, Constitutional Attorney and Past President, American Bar Association; William Adams, Esq., Jacksonville, prominent in Constitutional Law and Economics; Frederick Karl, Esq., Tallahassee, former Supreme Court Justice; Hyatt Brown, Daytona Beach, former legislator and Speaker of the House of Representatives; Roy Pfautch, St. Louis and Washington, D.C., FMA Public Relations Consultant; and Louis C. Murray, M.D., Orlando, Chairman, Council on Legislation.

This Panel was requested to include in its deliberations consideration of legislative recommendations, future constitutional initiatives and petitions to the Supreme Court to review such issues as the contingency fee system.

The Panel met on October 26 and subsequently submitted a number of far-reaching recommendations to the Board. The Board held a special called meeting on November 20 to consider the Panel's recommendations and unanimously adopted the following professional liability program.

I. LEGISLATION

That the FMA propose the following concepts to be carefully explored as measures that may effectively address the professional liability crisis in Florida, and that these concepts be set forth in an FMA policy statement emphasizing the Association's willingness to consider all alternatives, and the desire to resolve this issue through the legislative process, if possible. Further, that the Association urge every consideration be given to the Barron no-fault proposal and any other alternatives that will remove medical malpractice from the tort system:

- Strengthen as rapidly as possible risk management programs for physicians.
- Utilize the FMA Council on Hospital Medical Staffs to study ways to reduce the number of incidents occurring in hospitals and educate physicians on risk management techniques.
- Review the situation in respect to "bad doctors" and develop some mechanism to strengthen the Board of Medical Examiners to deal with those physicians who may be substandard.
- Strengthen the current structured settlement statute.
- Review how arbitration panels might be effectively used to resolve medical malpractice disputes.
- Continue to review a cap on awards.
- Review screening panels and their effect on the early resolution of cases.
- Study options to modify the contingency fee system.
- Study the no-fault Workers' Compensation approach to medical malpractice (The Barron Plan).
- Review with the Florida Bar the use of "case spotters" in hospitals by trial lawyers.
- Consider the feasibility of mandatory insurance for physicians as a means of ensuring that patients who have meritorious cases have a means of compensation.
- Continue to review joint and several liability.
- Review proposals regarding "trip insurance".

In an effort to encourage the broadest possible consensus of understanding and cooperation, I have met with Senate President, Harry Johnston

and House Speaker, James Harold Thompson to discuss the professional liability issue. Both have indicated their concern and support for efforts to resolve the professional liability crisis. I met with the President of the Florida Bar, Gerald Richman, on December 11 and Governor Graham on December 13. As the Board directed, in my discussion with the Governor, the legislative leadership, and the Florida Bar, I have encouraged the possibility of a joint petition to the Supreme Court to review such issues as the contingency fee system.

II. FUTURE CONSTITUTIONAL INITIATIVES

The Board directed that immediate steps be taken to redraft Amendment 9 (for possible efforts to have the amendment placed on the 1986 election ballot if necessary) to include that proposal or proposals which actuarially offer to have the most effective favorable impact on the professional liability crisis and which can be determined to best meet the single subject requirement for constitutional initiatives. And further, that outside legal counsel be retained to review the feasibility of presenting the amendment to an appropriate court for a declaratory judgment as to its constitutionality prior to presenting signature petitions to the public.

III. GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE

The FMA will actively cooperate and participate in the deliberations of the Governor's Task Force and encourage the development of meaningful tort reform proposals by the Task Force to be submitted for consideration by the 1985 Legislature.

The Task Force is specifically charged to examine and identify issues and information relating to medical malpractice in Florida and shall develop policy recommendations addressing the legal, disciplinary, regulatory, financial and marketplace considerations necessary to assure a cost effective, fair and reasonable system of compensation and justice in Florida.

The first meeting of the Task Force was held November 29, and as your President, I presented formal testimony on the scope of the malpractice problem at this hearing. The Task Force will hear recommendations for a solution at subsequent meetings.

In addition, on November 7, I made a presentation on the cost of medical malpractice to the Florida Task Force on Medical Malpractice. This Task Force which is comprised of a statewide membership from private business people, government leaders and health care professionals will no doubt have significant influence on the Governor's Task Force in developing tort reform proposals.

In looking back, we achieved many positive accomplishments through the Reason '84 Constitutional Initiative Campaign, including a strong public awareness of the severity of the professional liability problem and support for its resolution. The Governor and other legislative leaders have publicly acknowledged professional liability as a serious problem in our state and have expressed a willingness to work for effective and equitable tort reform. In addition, the Florida Bar has extended a formal offer to work with the FMA in seeking solutions to the professional liability issue. Also, we have the continuing support of many allied organizations, as well as business and industry.

In looking ahead, we must resolve to continue to work for reason and justice in Florida's tort system. Through a united effort, we will ultimately be successful in bringing an end to this devastating problem that has and continues to plague physicians and the public alike. I will keep you advised in a timely manner regarding our ongoing professional liability activities.

Frank C. Coleman MD

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Medical ghosts of Christmases past

Exactly six decades ago, I had just completed my first step toward a career in medicine — or writing about it. That unromantic event was the completion of a course listed in the catalog of Trinity College — then only a year away from becoming Duke University — as "Cat Anatomy." In the six decades since that Christmas, as surgeon and author, I have seen hundreds of medical ghosts appear, some to remain and become eras in their own right; more to achieve brief fame as cures, then fade into obscurity. But I'm still convinced that the next, and probably most important specter is waiting around the corner to be visualized by one of those fortunate people whose creative intelligence gives them every right to be called "ghost seers."

Centuries ago, some unnamed Alpine doctor must have marveled that most of his patients who were arsenic eaters rarely, if ever, got syphilis — Tyroleans often chewed the white powder they mined which increased the number of red cells in their bloodstream, making them virile. If he had recorded this, Dr. Ehrlich would not have patiently tested 605 chemicals until he found the arsenical compound he numbered 606, a painful and often dangerous cure of syphilis that flew its ghostly course for several decades before being replaced by penicillin. And how many specimens of *penicillium notatum* must have been blown through the open window of Dr. Alexander Fleming's laboratory until, in 1929, one killed the bacteria growing around it — and turned a ghost into a miracle — penicillin.

Back in 1924 if you cut your finger, you poured in iodine, cursed from the sting, and wrapped it up — perhaps dying of sepsis; like the young mothers in Vienna whom Dr. Ignaz Semmelweis tried to save from death in 1847 by teaching doctors and students to wash their hands between the dissecting rooms and the delivery rooms — and was laughed at for his pain. It was nearly eighty years later before a chemical was discovered that could kill bacteria in vivo. With the capacity to give the skins of those it cured from myriads of infections a faint blue color, sulfanilamide was a bit more ghostly than real in failing to attack many bacteria, but the offspring it begat over the next decade proved to be far more facile. One of them, in a single five gran dose, given in one day to 18,000 draftees at a military base, stopped an epidemic of meningitis in its tracks.

Yes, the six decades of medicine I have lived through have brought a procession of ghosts — some malignant like AIDS, others benign. The latest is the fabulous NMR diagnostic machine that makes atoms turn flip-flops under a giant magnet, revealing in the process some of the most intimate actions and reactions of body tissues — and while they live, not on Dr. Quincy's marble topped autopsy table. From whence will they come in the future, these ghosts of diseases past, cures cast away in favor or stronger ones, and, regrettably new diseases that, like AIDS, are for the moment incurable. Where will the next true Panacea be found trailing "clouds of glory?"

Nobody knows the answer, of course. But with forms of medical ghosts-to-be teaming in the world around us, they will certainly make their substance visible one day to those most fortunate of individuals, whether in science, literature or elsewhere, called "ghost seers."

Frank G. Slaughter, M.D.
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Use of the Swan-Ganz catheter

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ABSTRACT: Development of the Swan-Ganz catheter and the information it provides are reviewed. The thermodilution technique for measuring cardiac output, use of mixed venous oxygen pressure in assessing cardiovascular function and pitfalls associated with measuring and interpreting pulmonary capillary wedge pressure are discussed in detail. Useful advice is provided on how to use the Swan-Ganz to best advantage in the care of critically ill patients.

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In the 1940s Cournand and his colleagues[1] at Bellevue began to regularly insert catheters into the right side of the heart and pulmonary artery of patients for the purpose of measuring pressures, obtaining blood, and assessing cardiac function. This revolutionary technique was quickly adopted by others, both for patient care and research. One of the earliest groups to adopt it was Dexter's at Harvard and, while working with patients, they noted that when the catheter was introduced as far as possible into the pulmonary artery, in effect wedged into place, the extracted blood had a very high oxygen saturation.[2] Indeed, the oxygen saturation was equal to that of femoral artery blood. They presumed that this blood came from pulmonary capillaries. The same group later wedged catheters into the pulmonary vasculature and found positive pressure readings, not zero as they expected in a supposedly no flow situation.[3] They quickly realized that since the pulmonary venous circulation has no valves, this pressure might actually represent an equilibrium pressure with the richly anastomotic capillary and venous circulation. Lagerlof and Werko,[4] using a similar technique, reported that the pressure recordings from this wedged catheter had a phasic variation resembling that of the left atrium.

The significance of these findings was hotly debated; many believed that it was impossible for phasic pressures to be accurately transmitted backward through a capillary system to such a wedged catheter.[5] However, by simultaneously measuring left atrial and pulmonary capillary wedge pressure, it was clearly shown[6] that a pulmonary capillary wedge pressure did accurately reflect pressures in the left atrium. Further, assuming the absence of mitral valve and left atrial disease, these readings

also directly reflect the left ventricular pressures when the atrioventricular valve was open, or the left ventricular end diastolic pressure ($LVED_p$).

Despite the potential clinical value of these readings, the requirement for fluoroscopy to position the catheter limited their use until the development by Rahn's group in Rochester of a catheter with an inflatable balloon at its tip which allowed them to be "floated" into position.[7] The balloon acted as a sail, allowing the blood flow to push it into the pulmonary artery. This technique was so simple that even novices could quickly position the catheter at the bedside without fluoroscopy. Swan and Ganz, with others,[8] further modified this balloon tipped catheter so that now it can be safely and easily floated into position at the bedside, periodically wedged into the pulmonary circulation and kept in position for repeated measurements. The commercial development of this modified catheter led to its being referred to as the Swan-Ganz catheter.

Now that this marvelous technological device has been developed, we, the clinicians, are faced with two rather straightforward but oftentimes quite difficult questions: When do we use the Swan-Ganz? How do we interpret the information we get from it? It is difficult, if not impossible, to give a cookbook answer to the first question as clinical situations and the individual clinician's approach vary. Rather than listing situations and describing algorithms for the use of the Swan-Ganz, let's instead discuss what information this device can provide. When information only the Swan-Ganz can provide is needed for optimal patient management and if we can appropriately interpret that information, the Swan-Ganz should be inserted.

The Swan-Ganz catheter provides a clinically practical method for obtaining three different pieces of information. These include measurements of cardiac output and intravascular pressures as well as access to mixed venous blood in the pulmonary artery. Each piece of information may be interpreted alone or all three may be used together in a comprehensive evaluation of the cardiovascular system.

Cardiac output • When the Swan-Ganz catheter is specially modified to include a thermistor tip at its distal end,[9] it is quite suitable for measuring cardiac outputs by the thermodilution technique. This technique is basically an indicator dilution one with the indicator being saline or dextrose in water at a different temperature from blood. A known volume of injectate at a known temperature is injected through the proximal port of the Swan-Ganz (Fig. 1) into the right atrium. The injectate is mixed with blood in the right side of the heart, changing the temperature of the blood. During systole, blood at the modified temperature is ejected into the pulmonary artery and passes the distal tip of the Swan-Ganz. The thermistor at this distal tip senses the changes in temperature of the blood flowing past it. A computer attachment will integrate this change in temperature and use the Stewart-Hamilton equation[10] to calculate the cardiac output (Fig. 2).

Cardiac outputs measured by this thermodilution method have been shown to correlate very closely with those measured by both the direct Fick[11] and the cardiac green indicator dilution curves.[10] Indeed, a recent review has emphasized the reliability of thermodilution cardiac output measurements, provided two guidelines were followed.[12] These authors believe that three separate determinations should be obtained and averaged to get a single measurement. They also noted that a 15% change between measurements (each of which was the average of three separate determinations) was necessary to ensure statistically significant differences. As for technical factors, this

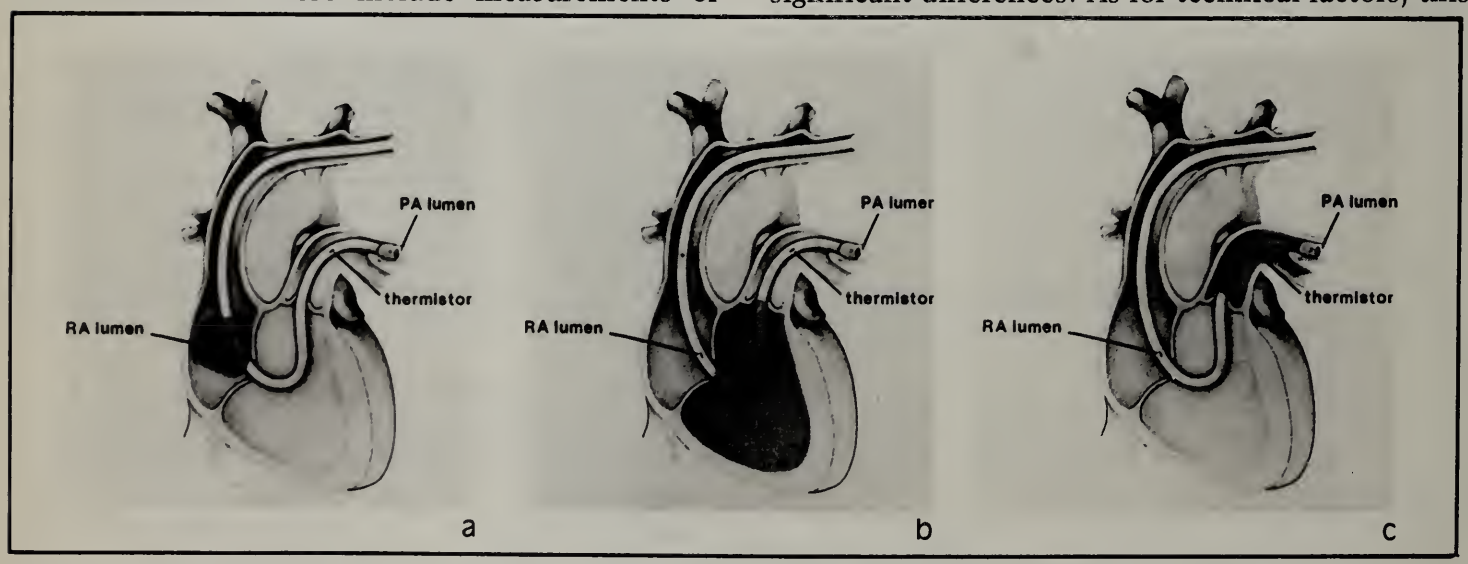
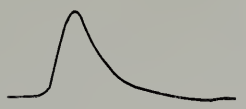


Fig. 1. — (a) Indicator being injected through proximal port or Swan-Ganz into right atrium; (b) indicator is mixed with blood in right ventricle; (c) indicator mixed with blood is ejected into pulmonary artery and passes thermistor near the distal tip of Swan-Ganz.

STEWART - HAMILTON EQUATION FOR CARDIAC OUTPUT BY THERMODILUTION

$$C.O._{TH} = \frac{53.6\ (T_B - T_I)}{\int_o^{\alpha} \Delta T_B\ (T)dt}$$



T_B = temperature blood

T_I = temperature injectate

Fig. 2. — The Stewart-Hamilton equation[10] and a wave form example of the change in blood temperature noted by the thermistor are shown.

same review found that commonly available commercial thermodilution catheters were just as accurate as custom made devices used in cardiac catheterization laboratories, and that iced injectant offered little advantage over room temperature injectate (except possibly in cases of hypothermia) as long as the injection was performed rapidly and smoothly.

A baisc question is whether clinical assessment, including physical examination, chest x-ray, and review of the hospital course by an experienced physician, would be just as accurate in determining cardiac output as the measurements obtained by the Swan-Ganz. This question is raised because for patients presenting with myocardial infarction, a simple clinical algorithm has been found to be almost as accurate a predictor of cardiac output as the thermodilution method.[13] Obviously, such a clinical approach would be far safer for the patient than having to insert a Swan-Ganz catheter. Unfortunately, in patients with complicated multisystem disease the clinical assessment has been shown to be quite inaccurate and to correlate poorly with Swan-Ganz measurements.[14] These findings clearly indicate that when a reliable cardiac output measurement is needed, thermodilution via the Swan-Ganz catheter is far superior to the clinical assessment and just as accurate as the Fick and other indicator dilution curves.

Mixed venous P_{02} • Cardiac output measurements are very useful in quantifying cardiac function, but this provides insight into only one aspect of overall cardiovascular performance. Also of crucial importance is the distribution of cardiac output and the adequacy of this blood flow in satisfying local tissue metabolic needs. Although the problem of blood flow distribution is quite complex and certainly cannot be adequately discussed here, in a very simple way the clinician can use the $P\bar{v}_{02}$ (partial pressure of oxygen in the mixed venous blood) as a general measure of the local tissue's supply of oxygen. In this way the $P\bar{v}_{02}$ can be used to complement cardiac output measurements in the assessment of the cardiovascular system, one quantifying cardiac function with the other quantifying tissue oxygen supply versus demand.

To use the $P\bar{v}_{02}$, one must appreciate first that capillaries supply cylinders of tissue with oxygen (Fig. 3). Oxygen diffuses out of the central capillary because a pressure gradient exists between the Pc_{02} (capillary P_{02}) and Pt_{02} (tissue P_{02}). The Pc_{02} is largest at the arterial end of the capillary and, as oxygen is lost to the tissues along the course of the capillary, it becomes smallest at the venous end of the capillary. Consequently, there will be a larger oxygen pressure gradient at the arterial end and oxygen will diffuse further outward from the capillary at that end. Conversely, there will be a smaller gradient at the venous end and oxygen will not diffuse outward as far there. This also means that when hypoxemia becomes a problem, the tissues at greatest risk for not getting an adequate supply of oxygen will be those at the venous end of the capillary (Fig. 4).

Since we cannot measure Pc_{02}, which would be the best indicator of oxygen pressure gradients, the next best indicator would be the venous pressure of oxygen as this represents the closest area to the critical venous end of the capillary. When the $P\bar{v}_{02}$ decreases, this would suggest a decreased Pc_{02} and a decreased

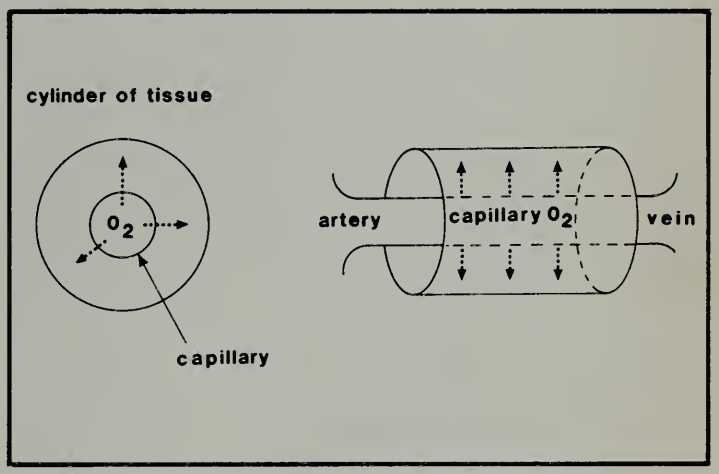


Fig. 3. — A capillary with the cylinder of tissue it supplies are shown in cross and longitudinal section.

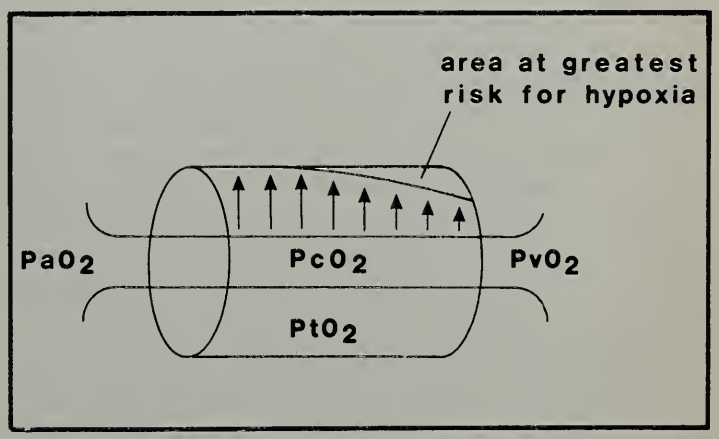


Fig. 4. — As shown in this figure, tissue hypoxia is most likely to occur at the venous end of the cylinder of tissue supplied by a given capillary.

$$Pt_{O_2}(X) = Pc_{O_2} - \frac{\dot{q}_{O_2}}{2 \cdot D_{O_2}} \left[R^2 \ln \frac{x}{r} - \frac{x^2 - r^2}{r} \right]$$

$\dot{q}_{O_2}$ = METABOLIC RATE

D_{O_2} = TISSUE DIFFUSION COEFFICIENT

r = RADIUS OF CAPILLARY

R = RADIUS OF DIFFUSION CYLINDER

X = DISTANCE FROM CAPILLARY WALL TO THE POINT IN QUESTION

Fig. 5. — Kety modification of Krogh-Erlang equation.

Pt_{O_2}. Of course, inadequate tissue oxygen supply would result in anaerobic metabolism and lactate production. The problem for the clinician is determining when Pt_{O_2} is inadequate so as to prevent lactic acidemia.

The Kety modification of the Krogh-Erlang equation[15] is an attempt to quantify tissue oxygen supply (Fig. 5). This equation is quite interesting as it considers several factors that clinicians usually fail to appreciate. These factors include the metabolic rate of the tissues, capillary size, size of the cylinder each capillary supplies (or the distance between capillaries) and the diffusivity of oxygen through the tissues. It also emphasizes that Pc_{O_2} is the key determinant of the pressure gradient for oxygen diffusion. This correlates quite nicely with the above theory that the tissues at greatest risk for being hypoxemic are those at the venous end of the capillary where the Pc_{O_2} would be lowest.

At present, we cannot measure clinically many of the variables needed to calculate the Pt_{O_2} by the Krogh-Erlang equation. However, we do have some insights into a threshold Pv_{O_2}, below which hypoxemia becomes significant and anaerobic metabolism with lactate production develops at the tissue level. Simmons et al[16] found in dogs that a $P\bar{v}_{O_2}$ below 27 mm Hg, whether caused by a reduction in cardiac output or hypoxemia, was consistently associated with hyperlactatemia. A very provocative study in humans[17] corroborated these findings. This study found that a group of patients with acute severe illness could easily be divided into those who survived and those who did not by a $P\bar{v}_{O_2}$ below 28 mm Hg. Interestingly, lactic acidemia was only found in those with a $P\bar{v}_{O_2}$ below 28 mm Hg. The Pa_{O_2} did not as accurately predicate lactate production or survival.

Although the $P\bar{v}_{O_2}$, when interpreted as an index of tissue oxygen needs, may provide an insight into the adequacy of cardiac output and its distribution, several factors can invalidate its usefulness. Most important of these is faulty sampling technique. Overvigorous withdrawal of blood or sampling when the tip of the catheter is wedged in small pulmonary arteries may result in the aspiration of oxygenated pulmonary capillary blood. This, of course, will give a falsely elevated $P\bar{v}_{O_2}$. Aside from technical problems, since the $P\bar{v}_{O_2}$ represents the total venous return, high $P\bar{v}_{O_2}$'s from certain organs may negate low $P\bar{v}_{O_2}$'s from other areas. In the future $P\bar{v}_{O_2}$ of key organs, such as the brain or kidney, may be more meaningful. Also, uptake of oxygen requires functioning cells and, under conditions of severe cellular damage, cells may actually fail to take up oxygen. In this situation, described as hypoxic-dysoxia by Robin,[18] the $P\bar{v}_{O_2}$ would be inappropriately high. Futhermore, either arteriovenous shunting at the local level or recruitment of capillaries would seriously undermine the usefulness of the $P\bar{v}_{O_2}$ in assessing tissue oxygen supply. In each, of course, the $P\bar{v}_{O_2}$ might increase, but in the former the Pt_{O_2} would decrease because blood is shunted away from capillaries; while in the latter, it might increase since the distance between capillaries decreases and oxygen availability to tissues would increase. Finally, some studies have indicated that PEEP may affect the usefulness of $P\bar{v}_{O_2}$.[19] This may occur because PEEP causes a redistribution of organ blood flow.[20] Despite these potential objections, the $P\bar{v}_{O_2}$ may be used as a cautionary signal. Specifically, a $P\bar{v}_{O_2}$ below 28 mm Hg may indicate local tissue hypoxemia and impending lactic acidosis. Using the $P\bar{v}_{O_2}$ then as an indicator of the adequacy of local blood flow and tissue oxygen supply nicely complements cardiac output measurements in assessing overall cardiovascular performance.

Intravascular pressure measurements • A central lumen runs the length of the Swan-Ganz catheter to an opening at its most distal tip. The distal tip, of course, will be located in the pulmonary artery. The proximal opening of this lumen, which is outside the patient, is connected to a pressure transducer. To maintain patency of this lumen, it is constantly flushed with a heparinized solution. Patency is essential because through the lumen pressures in the vascular tree are transmitted, by changes in pressure in the heparinized solution, to the pressure transducer. This transducer translates hydraulic pressures into electronic signals either wave form or digital which can be quantified as vascular pressure readings. The pressures obtained, the pulmonary artery pressure (PAP) and the pulmonary capillary wedge pressure (PCWP), are quite important to the clinician, particularly because they are so difficult to predict by clinical assessment.[14] Unfortunately, these pressures are also the most difficult to interpret. It is most important to understand the factors influencing these pressures for their proper interpretation.

Positioning of the Swan-Ganz: Technical factors are quite important in assuring accurate pressure monitoring. Since the distal opening of the Swan-Ganz is the critical point where vascular pressures interact with pressures in the catheter lumen, the distal tip must be positioned in a free flowing segment of the pulmonary artery. Impaction on a vessel wall may give distorted pressures. This may especially be a problem when the balloon at the tip of the Swan-Ganz is inflated for the blood flow may easily push the balloon into an impacted position. Also, the balloon itself may, when inflated, partially obstruct the distal lumen. Careful attention to wave forms and balloon inflation is needed to avoid accepting an "impacted" pressure as accurate. Another cause of impacted or damped pressure waves is clot formation obstructing the distal lumen. It has been clearly shown that the Swan-Ganz is thrombogenic and clot will coat it over time.[21] The constant heparinized flush attempts to limit this problem at the distal lumen but little information is available as to how long this will be effective. Heparin bonding of the Swan-Ganz may be of benefit in reducing this problem. An often overlooked technical problem is ensuring that the transducer system is free of air bubbles.

Aside from technical factors several pathologic conditions may affect interpretation of pressures, particularly the PCWP. As reviewed previously, the Swan-Ganz usually lies free in the pulmonary artery and periodically is wedged by inflating the balloon and allowing blood flow to push it into a smaller pulmonary artery. The balloon will then block pulmonary artery inflow and the distal tip will be open only to the pulmonary microvasculature. Since there are no pulmonary venous valves, this microvasculature includes the smaller pulmonary arteries, pulmonary capillaries, pulmonary veins, and even extends into the left atrium. Further, when the mitral valve is open, there should be an open communicating system into the left ventricle (Fig. 6). This means that the PCWP can actually reflect the left atrial (LAP) and left ventricular end diastolic ($LVED_p$) pressures unless, of course, there are pathologic obstructions in between the wedged pulmonary artery and the left ventricle. Such potential obstructions

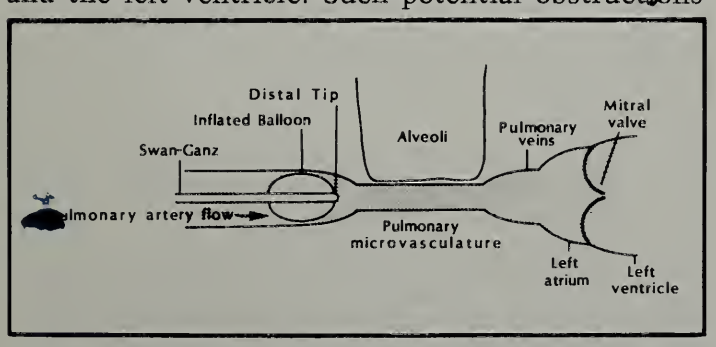


Fig. 6. — The Swan-Ganz is shown with the balloon inflated and the distal tip wedged. The distal tip is then exposed to only the pressure in the pulmonary microvessels and veins, left atrium and, during diastole, left ventricle.

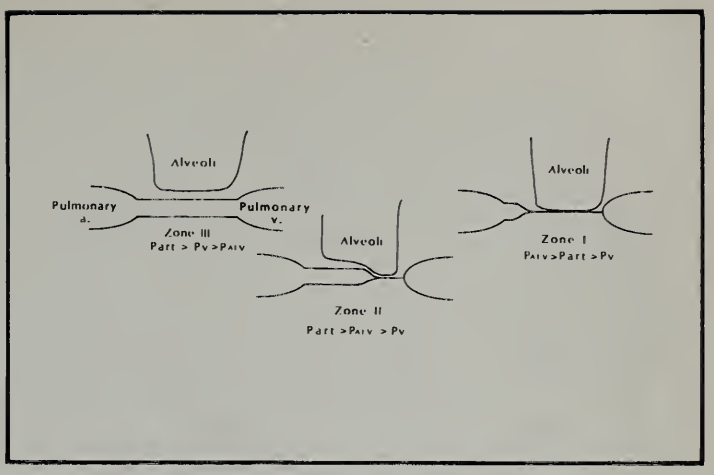


Fig. 7. — Zones I, II, and III are determined by the relative alveolar and vascular pressures. High alveolar pressures can obstruct venous and arterial flow as pictured.

include pulmonary veno-occlusive disease, subdiaphragmatic anomalous pulmonary venous return, mitral stenosis, cor triatriatum, and left atrial thrombosis. An important advantage of the Swan-Ganz catheter is that increased pulmonary vascular resistance from chronic obstructive lung disease or other pulmonary disorders does not affect the PCWP and its relation to LAP.

One other potential obstruction between the wedged Swan-Ganz and the left atrium and ventricle should be appreciated (Fig. 7). This is the alveolar pressure. In certain areas of the lungs, alveolar pressure may actually exceed either arterial or venous pressures and consequently obstruct flow. Indeed, the lung can be divided into different zones depending upon the relative alveolar to vascular pressure; zone I has alveolar pressure greater than arterial, zone II has alveolar pressure less than arterial but more than venous, and zone III has alveolar pressure less than venous pressure.[22] The preferential zone for Swan-Ganz positioning would be zone III in which alveolar pressures do not obstruct the path from pulmonary artery to left atrium. Zone III is found usually in the gravitationally dependent portion of the lungs. For patients in the supine position, it may be helpful to obtain lateral chest x-rays to ensure that the Swan-Ganz is indeed located below the level of the left atrium.[23] Alternatively, aspirating oxygenated blood from the distal tip when the balloon is inflated also indicates that the Swan-Ganz is appropriately placed in zone III. It should be realized that a PCWP from a catheter misplaced in zone I or zone II will not accurately reflect the LAP.[23] Such a catheter should be repositioned in zone III, if these pressure readings are clinically needed.

PCWP as a measure of preload: Assuming that the Swan-Ganz is correctly positioned in zone III, an undamped pressure reading is obtained and the pathological conditions previously discussed are not present, a PCWP will accurately reflect the LAP and $LVED_p$.[6] The $LVED_p$ does not directly measure left

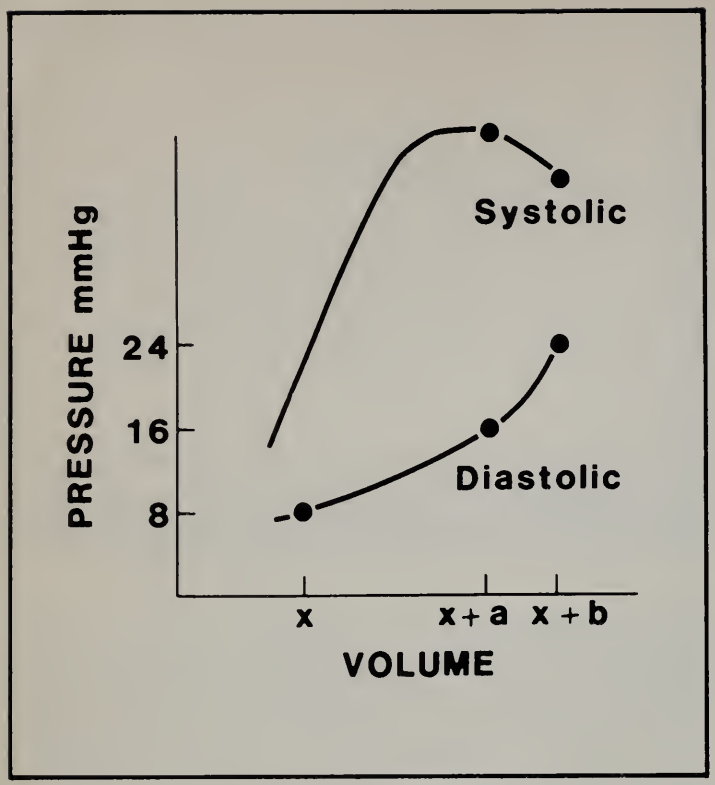


Fig. 8. — The adaptation of a classic graph shows how increasing the end diastolic volume of the left ventricle will increase both the end diastolic pressure and the energy released during the following systole.

ventricular function though but rather can be used to indirectly assess left ventricular preload. Preload is defined as the volume of blood in the ventricle at the onset of systole or the left ventricular end diastolic volume. The importance of preload is based on those myocardial characteristics described by Starling, Braunwald, and others,[24] that directly relate the mechanical energy or pressure developed during systole to the length of stretch of myofibrils just prior to systole (Fig. 8). Simply put, the larger the diastolic volume, the longer the myofibrils are stretched, then the more forcefully they will contract during systole until a certain point is reached when further stretch will instead cause deterioration in systolic function.

Three important points must be understood when using $LVED_p$ as a reflection of LV preload. First, for pressure to accurately reflect a certain volume, the compliance of the left ventricle must be constant. If the left ventricle becomes less compliant, stiffer, or inelastic, then a given volume of blood will cause a higher pressure. Conversely, if the left ventricle becomes more compliant, more stretchable, a given volume of blood will cause a lower pressure. This can easily be understood by comparing two balloons of different compliance. Inflating each balloon up to the same size or volume will require more effort (more pressure) in the stiffer, less compliant balloon than in the more compliant balloon. A variety of factors may affect the compliance of the left ventricle. These include pericardial disease, drugs such as vasodilators, vasopressors and nitroglycerin, changes in the right ventricular volume inducing alterations in the geometry of the left ventricle, intrinsic myocardial damage, and positive end expiratory pressure (PEEP). When left ventricular compliance changes, the relationship between $LVED_p$ and the assumed LVED volume, or preload, will also change (Fig. 9).

The second important point is that the volume of any hollow object will depend upon its pressure inside versus the pressure outside, or the net pressure at the wall of the object. This net pressure is known as the transmural pressure (Fig. 10). For the left ventricle, the transmural pressure will be determined by the distending pressure inside the ventricle, which is the vascular pressure, and the surrounding pericardial pressure. During normal breathing, the pericardial pressure, like the pleural pressure, will usually be slightly negative and can be ignored. However, during positive pressure ventilation, or during forceful inspirations, the pericardial pressures may be substantial. To minimize the effect of these pericardial pressures on the Swan-Ganz readings, it is best to measure pressures at end expiration when airway, pleural and pericardial pressures will be minimal. Measuring pressures from a strip chart recording of pressure waves, rather than digital readouts, will make it easy to appreciate the respiratory variations in the pressures and to determine end expiration.

When PEEP is used there will be constant external pressure preventing the vascular pressure from distending the left ventricle throughout the respiratory cycle. Consequently, the vascular pressure will not

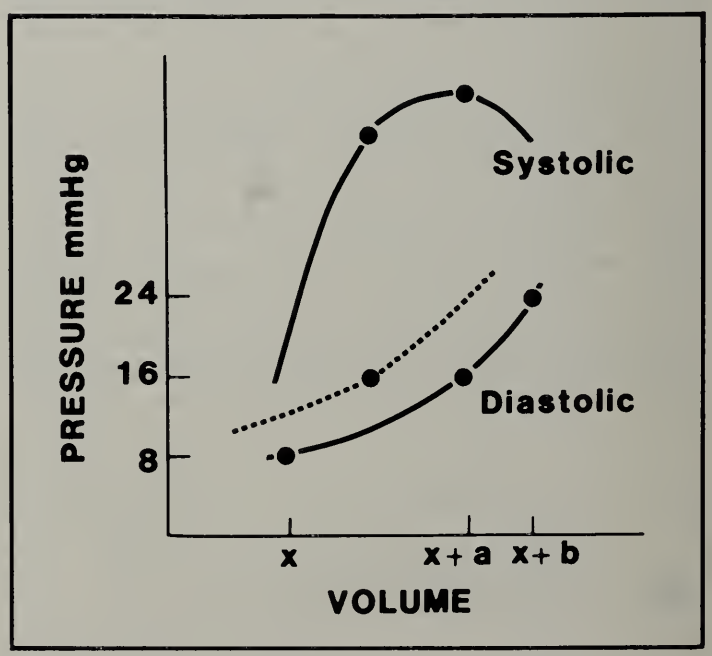


Fig. 9. — A less compliant left ventricle will have a higher pressure at a given end diastolic volume, as shown by the dotted line. The energy released during the following systole will be determined by the $LVED_{vol}$, not the $LVED_p$. This is demonstrated by the different points on the systolic curve, the higher one for the normally compliant left ventricle and the lower one for the less compliant left ventricle.

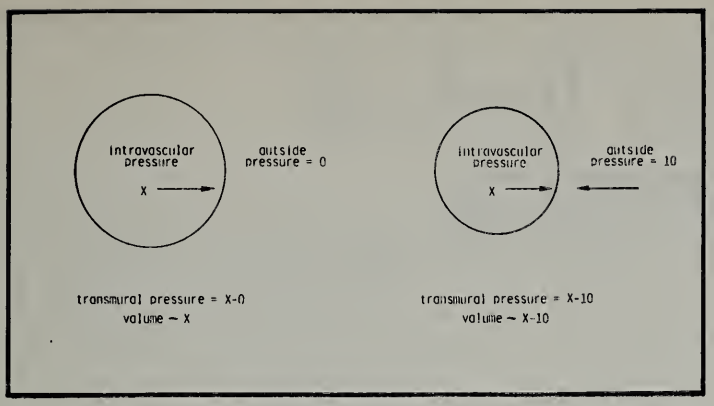


Fig. 10. — Although the internal pressure for both spheres is the same, X, the transmural pressure and volume for the sphere on the left are larger. The external pressure will reduce the transmural pressure and volume for the sphere on the right.

truly reflect the LV volume even during end expiration. Considerable controversy abounds over how to "correct" the PCWP for this PEEP effect. Discontinuing PEEP to measure PCWP is unwise because dramatic deoxygenation may occur.[25] Also, reductions in PEEP may result in acute increases in venous return. Esophageal balloons have been used to measure pleural pressures during PEEP but such pressures may not accurately reflect pericardial pressures, especially with PEEP.[26] A simple, but rough, guide for calculating the transmural $LVED_p$, as a better measure of preload, when PEEP is applied is to subtract half the airway pressure in mm Hg from the PCWP.[27] If the lungs are stiff from diffuse damage, either pneumonia or edema, airway pressure is not as effectively transmitted to the pericardium so subtracting one third of the airway pressure in mm Hg from the PCWP is suggested.[28]

Finally, it should be understood that the preload, as inferred from the PCWP, is just one determinant of left ventricular function. The other determinants, the contractile state of the myocardium, left ventricular afterload, and the heart rate, cannot be assessed from the vascular pressures obtained by the Swan-Ganz.

Conclusion • The Swan-Ganz catheter is a marvelous technological device which allows us to measure intracardiac intravascular pressures and cardiac outputs as well as to obtain mixed venous blood. Important information can be obtained which is oftentimes not readily obvious through careful clinical assessments. Cardiac outputs and the Pv_{02} may be especially complementary in assessing a patient's overall cardiovascular performance. Pressure measurements must be interpreted carefully, particularly when the PCWP is being used to assess left ventricular preload. The compliance of the left ventricular, the concept of transmural pressure and the realization that preload is just one of several factors determining left ventricular function must all be considered when relying on PCWP.

References

1. Cournand, A. and Ranges, H.A.: Catheterization of the Right Auricle in Man, Proc. Soc. Exper. Biol. Med. 46:462-466, 1941.
2. Dexter, L.; Haynes, F.W.; Burwell, C.S.; Eppinger, E.C.; Sagerson, R.P., and Evans, J.M.: Studies of Congenital Heart Disease. II, Pressure and Oxygen Content of Blood in the Right Auricle, Right Ventricle and Pulmonary Artery in Patients, with Observations on the Oxygen Saturation and Source of Pulmonary "Capillary" Blood, J. Clin. Invest. 26:554-560, 1947.
3. Hellems, H.K.; Haynes, F.W.; Dexter, L., and Kinney, T.D.: Pulmonary Capillary Pressure in Animals Estimated by Venous and Arterial Catheterization, Am. J. Physiol. 155:98-105, 1948.
4. Lagerlof, M. and Werko, L.: Studies on Circulation of Blood in Man VI. The Pulmonary Capillary Venous Pressure Pulse in Man, Acta Physiol. Scand. 16:147-161, 1948.
5. Editorial, Pulmonary Wedged Catheter Pressures, Circ. Res. 1:371-374, 1953.
6. Walston, A. and Kendall, M.E.: Comparison of Pulmonary Wedge and Left Atrial Pressure in Man, Am. Heart. J. 86:159-164, 1973.
7. Lategola, M. and Rahn, H.: Self-Guiding Catheter for Cardiac and Pulmonary Arterial Occlusion, Proc. Soc. Exper. Biol. Med. 84:667-668, 1953.
8. Swan, H.J.C.; Ganz, W.; Forrester, J.; Marcus, H.; Diamond, G., and Chonette, D.: Catheterization of Heart in Man with Use of Flow-Direct Balloon Tipped Catheter, N. Engl. J. Med. 283:447-451, 1970.
9. Forrester, J.S.; Ganz, W.; Diamond, G.; McHugh, T.; Chonette, D.W., and Swan, H.J.C.: Thermodilution Cardiac Output Determination with a Single Flow-Directed Catheter, Am. Heart J. 83:306-311, 1972.
10. Sorensen, M.B.; Bille-Brahe, M.E., and Engell, H.C.: Cardiac Output Measurement by Thermal Dilution, Ann. Surg. 183:67-72, 1976.
11. Branthwaite, M.A. and Bradley, R.D.: Measurement of Cardiac Output by Thermal Dilution in Man, J. Appl. Physiol. 24:434-438, 1968.
12. Stetz, C.W.; Miller, R.G.; Kelley, G.E., and Raffin, T.E.: Reliability of Thermodilution Method in Determination of Cardiac Output in Clincial Practice, Am. Rev. Resp. Dis. 126:1001-1004, 1982.
13. Forrester, J.S.; Diamond, G.A., and Swan, H.J.C.: Correlative Classification of Clinical and Hemodynamic Function After Acute Myocardial Infarction, Am. J. Cardiol. 39:137-145, 1977.
14. Connors, A.F.; McCaffree, D.R., and Gray, B.A.: Evaluation of Right Heart Catheterization in Critically Ill Patient Without Myocardial Infarction, N. Engl. J. Med. 308:263-267, 1983.
15. Tenney, S.M.: Theoretical Analysis of Relationship Between Venous Blood and Mean Tissue Oxygen Pressure, Respir. Physiol. 20:283-296, 1974.
16. Simmons, D.N.; Alpas, A.P.; Tashkin, D.P., and Coulson, A.: Hyperlactatemia Due to Arterial Hypoxemia or Reduced Cardiac Output, or Both, J. Appl. Physiol. 45:195-202, 1978.
17. Kasnitz, P.; Druger, G.L.; Yorra, F., and Simmons, D.H.: Mixed Verrous Oxygen Tension and Hyperlactatemia, JAMA 236:570-574, 1976.
18. Robin, E.D.: Of Men and Mitochondria: Coping with Hypoxic Dysoxia, Am. Rev. Resp. Dis. 122:517-531, 1980.
19. Danek, S.J.; Lynch, J.P.; Weg, J.G., and Dantzker, D.R.: Dependence of Oxygen Uptake on Oxygen Delivery in Adult Respiratory Distress Syndrome, Am. Rev. Resp. Dis. 122:387-395, 1980.
20. Tucker, H.J. and Murray, J.F.: Effects of End-Expiratory Pressure on Organ Blood Flow in Normal and Diseased Dogs, J. Appl. Physiol. 34:573-577, 1973.
21. Chastre, J.; Cornud, F.; Bouchama, A.; Viau, F.; Benaccraf, R., and Gilbert, C.: Thrombosis as Complication of Pulmonary Artery Catheterization via Internal Jugular Vein; Prospective Evaluation by Phlebography, N. Engl. J. Med. 306:278-281, 1982.
22. West, J.B.: Ventilation/Blood Flow and Gas Exchange, pp 15-30. Blackwell Scientific Publication, Oxford, England 1977.
23. Shasby, D.M.; Dauber, I.M.; Pfister, S., et al: Swan-Ganz Catheter Location and Left Atrial Pressure Determine Accuracy of Wedge Pressure When PEEP Is Used, Chest 80:666-670, 1981.
24. Schlant, R.C.; Sonnenblich, E.H., and Gorlin, R.: Normal Physiology of Cardiovascular System. In: The Heart, New York, N.Y., McGraw-Hill Book Co., pp 75-114, 1982.
25. Divertie, M.B.; McMichan, J.C.; Michel, L.U.C.; Offord, K.P., and Ness, A.B.: Avoidance of Aggravated Hypoxemia During Measurement of Mean Pulmonary Artery Pressure in ARDS, Chest 83:70-74, 1983.
26. Marini, J.J.; O'Quin, R.; Culver, B.H., and Butler, J.: Estimation of Transmural Cardiac Pressures During Ventilation with PEEP, J. Appl. Physiol. 53:384-391, 1982.
27. Lenfant, C. and Howell, B.J.: Cardiovascular Adjustments in Dogs During Continuous Pressure Breathing, J. Appl. Physiol. 15:425-428, 1960.
28. Chapin, J.C.; Downs, J.B.; Douglas, M.E.; Murphy, E.J. and Ruiz, B.C.: Lung Expansion, Airway Pressure Transmission, and PEEP, Arch. Surg. 114:1193-1197, 1979.

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Hepatitis B: another look at prevaccination screening

Sonja Harrold Lessne, M.D.

ABSTRACT: The availability of a highly effective, safe hepatitis B vaccine makes in necessary for the general medicine practitioner to assess patients at risk for this disease and make vaccine available to them. Although the vaccine can be administered safely to all previously infected persons, its cost makes immunizing everyone at risk unreasonable without screening some for immune or carrier status. Current guidelines for prevaccination screening, however, do not take into consideration the situation in general medical care.

In general medical practice where the doctor-patient relationship is based on a contractual agreement between individuals, recommendations for prevaccine screening derived from studies which orient toward people as they relate to institutions, insurers or public health cannot be appropriately applied. The general practitioner is morally and contractually obligated to the individual patient and his or her family and therefore must apply a different standard to prevaccine screening.

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The availability of a highly effective, safe hepatitis B vaccine makes it incumbent on the general medical practitioner to assess patients at risk for this disease and make vaccine available to them. Although the vaccine can be administered safely to all previously infected persons, its cost makes immunizing everyone at risk unreasonable without screening some for immune or carrier status. Current guidelines for prevaccination screening, however, do not take into consideration the situation in general medical care. Studies which have analyzed the cost effectiveness of prevaccine screening have made recommendations based on the dollar costs to society, insurance companies, and large institutions.[1,2] However, these studies do not consider that in office practice the physician-patient relationship is quite different than the relationship of people to the public health department or other institutions. In the office the physician is responsible to the individual patient. Screening cannot leave unanswered questions or cause morbidity. For example, the Centers for Disease Control (CDC) recommends that screening start with determination of the hepatitis B core antibody (anti-HBc) or hepatitis B surface antibody (anti-HBs).[3] Core antibody can identify all previously infected persons but does not distinguish the carrier from those who are not carriers. Its presence may also indicate acute or chronic infection. Anti-HBs identifies previously infected persons who may be immune and are unlikely to have acute infection. However, recent reports indicate that the test for anti-HBs may be positive when in fact the person is not immune.[4] A positive anti-HBs may end in morbidity for such patients because they will not receive vaccine, will remain vulnerable to the disease and what's worse, because they are thought to be immune, will not be

Table 1. — Expected Hepatitis B Virus Prevalence in Various Population Groups.

	Prevalence of Serological Markers of HBV Infection	
	HBsAg (%)	All (%)
High Risk		
Immigrants/refugees from areas of high HBV endemicity	13	80-85
Residents in institutions for the mentally retarded	10-20	35-80
Users of illicit parenteral drugs	7	60-80
Homosexually active men	6	35-80
Household contacts of HBV carriers	3-6	30-60
Patients of hemodialysis units	3-10	20-80
Intermediate Risk		
Prisoners (male)	1-8	10-80
Staff of institutions for the mentally retarded	1	10-20
Health-care workers (frequent blood contact)	1-2	15-30
Low Risk		
Health-care workers (no or infrequent blood contact)	0-3	3-10
Healthy adults (first time volunteer blood donors)	0-3	3-5

From Centers for Disease Control ACIP MMWR (1982) 317-328.

treated if exposed.[5] On the other hand people who recommend screening with HBsAg forget that although this test can tell us about carrier status, it does not reveal anything about the patient's state of immunity or distinguish whether the presence of HBsAg indicates acute or chronic infection, an important distinction for the general practitioner.

The CDC has shown that prevaccine testing is appropriate for people who fall into certain high risk groups if the cost is reasonable.[6] In general, to be cost effective, screening should be done on those who are most likely to have chronic infection or immunity (Table 1) and use the fewest tests. As has been noted, however, in order to decrease the likelihood of falsely labeling a nonimmune person, rule out acute infection and identify those with chronic infection, it is necessary to screen with three tests: HBsAg, anti-HBs, and anti-HBc. For some patients three tests screening will be cost effective, for many it will not (Tables 2 and 3). Also, there are instances when patients who do not qualify for testing by cost effective criteria will desire testing. These people such as health care workers and others at similar risk consider their enhanced risk for hepatitis B and the implications of that risk a threat to their future health as well as that of their family. Many are wary of getting vaccine and prefer to know if they really need it. They often request testing in order to discover their status.

In general practice abnormal screening tests must be evaluated, thus, patients may incur costs beyond the original screening costs. For example, it is recommended that household contacts with acute infection need to be given HBIG (hepatitis B immune globulin), the acutely infected patient be followed to determine the outcome of the infection, and that

Table 2. — Cost Effective Screening Cost by Expected Prevalence of Serological Markers.*

Expected Prevalence of Serological Markers	Screening Costs* Cost Effective
%10	$<15.00
20	< 30.00
30	< 45.00
40	< 65.00
50	< 80.00
60	< 95.00
70	<110.00
80	<120.00

* Based on data from Centers for Disease Control ACIP MMWR (1982) 317-328.

Table 3. — Cost to Patient of Hepatitis Serology from Commercial Laboratories, Florida 1984.

	Profile*	HBsAg	HBsAb	HBcAb
Smith - Kline	$48.00	22.25	22.25	27.00
National Health Lab	74.00	31.00	42.00	40.00
Roche	67.00**	21.00	25.00	25.50

* Includes HBsAg, anti-HBs, anti-HBc

** Also includes anti-HAV IgM and IgG

chronic carriers, susceptible to many of the complications of chronic hepatitis, be followed regularly.[7] Household contacts of carriers especially the potentially pregnant sexual intimates must be evaluated for the presence of HBsAg. These women may transmit hepatitis B to their newborn. Administration of HBIG and vaccine to the infant is highly effective in preventing disease. It is, therefore, important to identify carrier mothers.[8,9] It is important to note that immunity is not permanent and those who have been considered immune, especially those who have had vaccine, should be retested periodically.

In general medical practice where the relationship is based on a contractual agreement between individuals, recommendations for prevaccine screening derived from studies which orient toward people as they relate to institutions, insurers or public health cannot be appropriately applied. The general practitioner is morally and contractually obligated to the individual patient and his or her family and, therefore, must apply a different standard to prevaccine screening and other issues dealing with hepatitis B infection and exposure.

References

1. Mulley, A.G.; Silverstein, M.D. and Dienstag, J.L.: Indications for Use of Hepatitis B Vaccine Based on Cost-Effectiveness Analysis, N. Engl. J. Med. 307:644-652, 1982.
2. Hamilton, J.D.: Hepatitis B Virus Vaccine, Analysis of Its Potential Use in Medical Workers, JAMA 250:2145-2150, 1983.
3. Centers for Disease Control: Inactivated Hepatitis B Virus Vaccine: Recommendations of Immunization Practices Advisory Committee, MMWR 31:317-321, 1982.
4. Sheretz, R.J. and Hoofnagle, J.H.: Antibody to Hepatitis B Surface Antigen May Not Always Indicate Immunity to Hepatitis B Virus Infection, N. Engl. J. Med. 309:1519, 1983.
5. Ware, A.J.; Gorder, N.L.; Gurian, L.E., et al: Value of Screening for Markers of Hepatitis in Dialysis Units, Hepatology 3:513-518, 1983.
6. Centers for Disease Control: Inactivated Hepatitis B Virus Vaccine: Recommendations of Immunization Practices Advisory Committee, MMWR 31:322-328, 1982.
7. Hoofnagle, J.H.: Types A and B Hepatitis, Perspectives on Viral Hepatitis, Abbot Laboratories Monograph, 1981.
8. Delaplane, D.; Yogev, R.; Crussi, F., et al: Fatal Hepatitis B in Early Infancy: Importance of Identifying HBsAg-Positive Pregnant Women and Providing Immunoprophylaxis to Their Newborns, Pediatrics 72:176-180, 1983.
9. Centers for Disease Control: Postexposure Prophylaxis of Hepatitis B: Recommendations of Immunization Practices Advisory Committee, MMWR 33:285-290, 1984.

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Recurrent parathyroid carcinoma: value of aggressive surgical approach

David H. Shapiro, M.D. and Rodrigo Jurado, M.D.

ABSTRACT: A patient is reported who has survived 25 years with multiple recurrences of parathyroid carcinoma. Since 1958 several procedures have been necessary to resect neck and pulmonary metastases. Most recently recurrent hypercalcemia could not be attributed to a lesion that could be localized. Renal function was at risk. A recurrent intrathyroidal parathyroid carcinoma was found at neck exploration and she remains normocalcemic with oral calcium replacement. The importance of an aggressive surgical approach is emphasized to remove recurrent lesions and avoid the eventually lethal effects of persistent hypercalcemia permitting long-term survival of the patient with parathyroid carcinoma.

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Carcinoma of the parathyroid gland is an unusual cause of hypercalcemia accounting for only 3-4% of all cases of primary hyperparathyroidism in various published series. Cumulative five year survival of 50% and ten year survival of only 13% was reported on a series of 43 patients from the NCI by Holmes et al.[1] It is generally recognized that recurrence associated with hypercalcemia is common and usually located in the neck and lungs. The goal of resection is palliative to control hypercalcemia and associated renal deterioration. This case report is notable because of the uncommonly long survival of the patient despite multiple recurrences and stresses the value of an aggressive surgical approach in permitting the patient to be spared the usually lethal renal lesion associated with unresected recurrences.

Case report • The 69-year-old white female underwent neck exploration in 1958 for presumed thyroid adenoma and a left thyroid lobectomy was performed. Permanent sections revealed parathyroid carcinoma. Over the subsequent ten years with localized tumor recurrence and hypercalcemia, she underwent left radical neck dissection, right upper lobectomy, right lower lobetomy and right and then left ureteral lithectomy. Persistently elevated serum calcium had been controlled with oral phosphorous preparations maintaining serum calciums in at 9-10 mg/dl. Serum ionized calcium had been 5.6 mg/dl, normal to 5.2 mg and a parathormone level of 2600 pg/ml with upper limit of normal of 630 pg/ml. She presented for surgical evaluation because of recurrent hypercalcemia. She had been treated with oral phophorous suppression causing precipitation of calcium phosphate in the renal parenchyma with deterioration of renal function. Her creatinine clearance was 24 ml/min.

Complete evaluation to attempt localization of metastatic disease was done. A CAT scan of the neck revealed some fullness to the right. Multiple venous samples for parathormone revealed no localizing "step-up." Arteriography was inconclusive.

On 2/6/81 she underwent exploration of the neck, with the hope of finding a lesion accounting for the parathormone production. The left neck, site of previous primary and recurrent tumor and radical neck dissection, was reexplored. No tumor was found. A group of normal nodes were biopsied. The right neck was then explored; no parathyroid glands were found. Accordingly a right thyroid lobectomy was done and an intrathyroidal 2 cm metastatic focus of parathyroid carcinoma was removed.

Serum calcium levels over a two year follow up have been maintained at 8-9 mg/dl with oral Neo-Calglucon. The patient has been able to enjoy milk and ice cream for the first time in ten years.

Discussion • Flye and Brennan have reported their experience with four patients treated at NIH for recurrent parathyroid carcinoma with one patient having survivied 17 years to the time of their publication in 1980.[2] They documented with a summary of 13 published reports from various authors the value of repeated resection in prolonging the survival of these patients.

The tumor usually recurs locally at the site of original resection or as cervical lymph nodal metastases. It also commonly presents as isolated or multiple pulmonary nodules as did the present case. Distant or diffusely infiltrative metastases do not seem to characterize patients with recurrent parathyroid carcinoma. They do not expire from this kind of cancer because of eventual organ destruction by tumor metastases; rather, when resection is not done, they succumb to the lethal effects of the persistently elevated calcium. This may take the form of cardiac arrhythmias, acute pancreatitis or, most commonly, progressive renal failure.

Nonsurgical alternatives have little to offer in terms of long-term benefits. Mithramycin, a chemotherapeutic agent especially effective against embryonal cell tumors, has been effective in lowering serum calcium.[3] Elias et al reported that Mithramycin's effect was on skeletal resorption rather than the tumor itself.[3] Continuous use is limited however by severe hepatic, renal and hematologic toxicity.[4] Hydration, chelating agents, citrate, sulfates, and dialysis have been used but with little long-term success. Steroids and phosphate infusions are the most successful.[5]

The patient reported here was receiving oral phosphate preparations which were effective in holding her serum calcium in the range of 10-11 mg despite a parathormone level of 3500 pg/ml. The hazard of this approach, however, is the deposition of calcium phosphate within the renal parenchyma resulting in progressive renal failure.

The optimal solution is clearly to remove the deposits of recurrent carcinoma where and whenever feasible. It is not the diffuse visceral involvement by metastases but the hypercalcemia that is the lethal factor. Since recurrences are often local they should be aggressively sought and removed. Schantz and Castleman in a report of 70 cases of parathyroid carcinoma noted that local recurrence occured in 30% and that metastases were usually late.[6] They observed that recurrence within two years usually was associated with poor prognosis.

In a recent update on the NIH experience, Flye and Brennan again stressed the usefulness of repeated resection of local recurrences.[2] The patient reported here has survived 25 years since her first resection, and now one year since her last operation she remains normocalcemic, and indeed requires oral calcium to maintain normal calcium levels. She has successfully undergone multiple neck explorations and pulmonary resections and is now radiographically and chemically free of disease.

References

1. Holmes, E.C.; Morton, D.L., and Ketcham, A.S.: Parathyroid Cardinoma: Collective Review, Ann. Surg. 169:631-640, 1969.
2. Flye, M.W. and Brennan, M.F.: Surgical Resection of Metastatic Parathyroid Carcinoma, Ann. Surg. 193:425-435, 1981.
3. Singer, F.R.; Neer, R.M.; Murray, T.M. et al: Mithramycin Treatment in Intractable Hypercalcemia Due to Parathyroid Carcinoma, N. England J. Med. 283:634, 1970.
4. Elias, E.G. and Evans, J.T.: Hypercalcemic Crisis in Neoplastic Disease, Management with Mithramycin, Surgery 71:631-635, 1972.
5. Elias, E.G.; Reynoso, G. and Mittelman, A.: Control of Hypercalcemia with Mithramycin, Ann. Surg. 175:431-434, 1972.
6. Schantz, A. and Castleman, B.: Parathyroid Carcinoma, Study of 70 Cases, Cancer 31:600-605, 1973.

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SPECIAL ARTICLE

Continuing Medical Education: a national and state overview

Pierre J. Bouis Jr., M.D. and Robert C. Fore, Ed.D.

To understand the development of the formal concept of Continuing Medical Education in the United States, one must journey back in time to 1955 when a report from the Council on Medical Education of the American Medical Association entitled "Post-Graduate Medical Education in the United States" was presented. The Council on Medical Education urged the Board of Trustees of the AMA to appoint an Advisory Committee on Post-Graduate Medical Education to study the report and develop objectives and principles for "Post-Graduate Medical Education." In 1957, a guide regarding objectives and basic principles of Post-Graduate Medical Education was distributed to agencies sponsoring continuing medical education programs. Almost immediately, a panel was commissioned by the AMA to conduct evaluations of continuing medical education programs. A new set of guidelines was prepared and distributed in 1960 and the phrase "Post-Graduate Medical Education" was deleted in favor of the term "Continuing Medical Education." Post-Graduate Medical Education was now reserved as a descriptive term for residency training. Methods to evaluate continuing medical education programs were refined and upgraded in 1962.

Although formal approval of sponsoring agencies began in 1967, it was not until 1970 that the House of Delegates of the American Medical Association adopted the "Essentials for the Accreditation of Institutions and Organizations Offering Continuing Medical Education." These "Essentials" were used by the Committee on Accreditation for accrediting National Continuing Medical Education programs and State Medical Associations as sponsoring agencies for intrastate programs.

In 1972, the Coordinating Council on Medical Education was formed by representatives from five agencies: American Medical Association, Association of American Medical Colleges, American Board of Medical Specialties, American Hospital Association and the Council of Medical Specialty Societies. This Council was designed to implement policy for both undergraduate and graduate medical education, including continuing medical education. During this time, however, it was becoming evident that the area of continuing medical education demanded more attention in the form of its own governing system. Although it took five years, this effort was finally realized in 1977 when the Liason Committee for Continuing Medical Education (LCCME) was activated. In addition to having representatives from the five founding organizations of the Coordinating Council for Medical Education, the LCCME included members of the Association for Hospital Medical Education and the Federation of State Medical Boards. The LCCME was to function in partnership with the AMA in developing better quality continuing medical

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education for all physicians. However, organizational problems arose and the functioning ability of the LCCME became questionable.

Because of the turmoil which developed over the creation of the LCCME, the AMA withdrew its membership by a vote of the House of Delegates in July of 1979. The AMA reauthorized its Council on Medical Education to renew accreditation standards for sponsors of continuing medical education. The Committee on Accreditation of Continuing Medical Education, a direct arm of the Council, became the specific voluntary accrediting agency of the AMA. However, the LCCME continued to function independently of the Council and operated its own system of accreditation with the support of the Council on Medical Specialty Societies. In 1981 the LCCME and the AMA reconciled their differences and both groups merged to form the Accreditation Council for Continuing Medical Education (ACCME). The ACCME receives its support and authority from the following: American Board of Medical Specialties, American Hospital Association, American Medical Association, Association for Hospital Medical Education, Association of American Medical Colleges, Council of Medical Specialty Societies and the Federation of State Medical Boards of the U.S., Inc.

The ACCME is now "The Accrediting Agency" for Continuing Medical Education in the United States, and developed its first set of "Essentials" in 1981. However, these "Essentials" were revised in the spring of 1983 and the revised edition has become the guide by which all agencies seeking accreditation are evaluated. The "Essentials" describe the minimal standards necessary for an institution or organization to meet the requirements for accreditation. There are seven "Essentials" and each specifically addresses an area felt by the ACCME to be vitally important to an agency in its ability to provide quality continuing medical education. The "Essentials" demand that an accredited sponsor of continuing medical education be accountable for the following areas in each CME activity: development of objectives, educational needs assessment, selecting appropriate faculty and educational methods, identifying the physician audience for whom the program is designed and program evaluation.

At present, there are approximately 2400 accredited sponsors of Continuing Medical Education in the U.S.

At present, there are approximately 2400 accredited sponsors of Continuing Medical Education in the U.S. Some 400 institutions and organizations have been directly accredited by the ACCME and the remaining 2000 sponsors have been accredited by State Medical Societies. Those sponsors whose scope of activities is on a national level apply directly to the ACCME while intrastate sponsors typically seek accreditation by State Medical Societies.

The Florida Medical Association acts on behalf of the ACCME in reviewing applications for accreditation and conducting on-site visits to evaluate programs of continuing medical education. Specifically, the Florida Medical Association Committee on Medical Education serves as the accrediting body and evaluates programs according to the "Essentials." Currently, there are 28 institutions and organizations in Florida accredited directly by the Florida Medical Association.

In addition to the accreditation process conducted by the Florida Medical Association, a mandatory program of continuing medical education is required of all members.

In addition to the accreditation process conducted by the Florida Medical Association, a mandatory program of continuing medical education is required of all members. This program was established May 6, 1972 when the House of Delegates, acting upon the recommendation of the Council on Scientific Activities, approved:

> "That 30 hours of continuing medical education be established as a minimum requirement for maintenance of Association membership to become effective January 1, 1974, with guidelines and procedures for fulfilling this requirement to be developed by the Committee on Continuing Medical Education for presentation to the House of Delegates in 1973."

Subsequently, practical application of the program has required several modifications and currently members are required to earn at least 150 credit hours during a three year cycle. Initially, members were allowed to begin their cycle on January 1, 1974; January 1, 1975, or January 1, 1976. Newer members have begun their cycle on January 1st immediately following the date of membership in their county medical society.

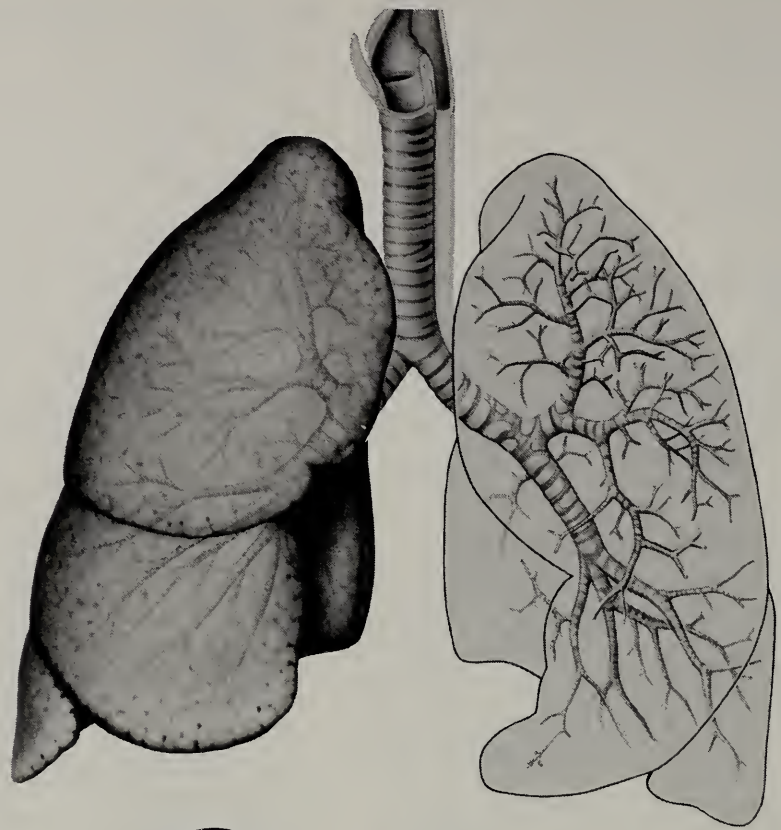
From an historical perspective, the Oregon Medical Association in 1970 was the first state medical association to establish a mandatory continuing medical education requirement. There are currently 12 states that have mandatory requirements, and nine including Florida accept the Physicians' Recognition Award (PRA) as fulfillment of that requirement.

There are 24 states and territories with legislated continuing medical education requirements for re-registration of the license to practice medicine. Only 17 of these states have implemented written regulations which are operational. Florida has no continuing medical education requirement for re-registration of licensure.

While the debate continues over mandatory versus voluntary programs of continuing medical education, few physicians proceed through their professional careers without actively seeking additional formal and informal training. While the amount of hours devoted to these activities may be mandated, the individual physician is the only one who can choose the most appropriate content. By assessing their own individual needs, physicians are better prepared to transfer learning to improved patient care which is the ultimate goal of all continuing medical education activities.

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Consider the causative organisms...



Ceclor®
cefaclor
250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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FLORIDA MEDICAL

DEPARTMENTS

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NOTES & NEWS

Plans completed for 1985 Leadership Conference

"Quality Medicine In A Rapidly Changing Environment" will be the theme of the Florida Medical Association 1985 Leadership Conference scheduled to be held Friday to Sunday, February 1-3, 1985 at the Tampa Airport Marriott Hotel in Tampa, Florida. Programs planned for the conference will address the dramatic changes which have occurred in medical practice in recent years as well as current and future alterations which will continue to affect the delivery of medical care.

A Leadership Skills Seminar for Women Physicians will launch the conference on Friday beginning at 8:15 a.m. Co-chaired by Kay K. Hanley, M.D. and Margaret C.S. Skinner, M.D., this is the first such program of its type to be presented in Florida. It promises to be an excellent forum for discussion on the subjects of women physicians in organized medicine, in the legislative process and in leadership roles. A roundtable luncheon will follow the speakers' presentations.

Two programs co-sponsored by the FMA and the Florida Medical Association Auxiliary will be held simultaneously on Friday afternoon from 1:30 p.m. to 4:00 p.m. Registered Parliamentarian and author of "How To Run A Medical Meeting," Rufus K. Broadaway, M.D., will present a Workshop on Parliamentary Procedure. Mr. Clarence Jones, of Marathon, an expert on investigative reporting and broadcast journalism, will advise physicians on "How To Deal With The Media" in a separate workshop.

Beginning at 4:15 p.m., a one-hour scientific section during a General Session is scheduled. World recognized immunologist Robert A. Good, M.D., of Tampa, will speak on "Clinical and Fundamental Approaches to Cellular Engineering." Dr. Good, who presently serves as Professor of Pediatrics and Graduate Research Professor for the University of South Florida College of Medicine and Physician-in-Chief and Chairman of the USF Department of Pediatrics at All Children's Hospital, is one of the most cited medical and biological scientists of our time. Among his most notable contributions has been the discovery of the most useful methods to foster bone-marrow transplantation as an approach to cellular engineering.

Friday's activities will end with an early bird reception from 6:00 p.m. to 7:00 p.m.

Breakfast on Saturday at 8:00 a.m. will be followed at 9:00 a.m. by keynote speaker Paul Starr, winner of the 1984 Pulitzer Prize for non-fiction as author of "The Social Transformation of American Medicine." Mr. Starr, who is an Associate Professor of Sociology at Harvard University, will discuss the United States medical establishment and its revolution toward health care, as well as his theories on the future of medicine.

From 10:00 a.m. to 11:45 a.m., Leadership Conference participants may choose to attend a workshop on Legislation, Public Relations, Medical Economics or Hospital Medical Staffs. Topics covered in these workshops will include:

Legislation

- The FMA Legislative Machine
- The Capitol Scene
- View From The Hill — How It Works In Washington
- Specialty Groups
- Communicating With The Legislature

Public Relations

- Public Relations in Medical Practice
- External Public Relations Projects For County Medical Societies

Medical Economics

- Status of the FMA Council on Medical Economics
- Current Trends in Health Economics and Organization
- Recent Activities of Government in Medicare and Medicaid Programs
- The Impact of Health Care Delivery Changes on the Individual Physician

Hospital Medical Staffs

- Key Issues Facing Hospital Medical Staffs on National and State Levels
- Current Trends of Hospital Medical Staffing on the National Level

The State Perspective of the Hospital Medical Staff Section and How the FMA Council on Hospital Medical Staffs Will Operate

The workshops will be repeated on Saturday from 1:30 p.m. to 3:00 p.m. following a 12:00 luncheon (speaker to be announced).

A General Session will begin at 3:15 p.m. with a briefing on FMA Programs by FMA President Frank C. Coleman, M.D., followed by a scientific section from 4:15 p.m. to 5:15 p.m. on "Doctor-Patient Communications" by David Pendleton, Ph.D., a Professor at Kings Fund College in London. There will be a reception Saturday evening beginning at 6:30 p.m.

On the final day of the Conference, a Prayer Breakfast is planned at 8:00 a.m. Senator Dempsey Barron, D-Panama City, will discuss professional liability and tort reform as part of a Legislative Briefing scheduled to begin at 9:00 a.m. Opening the briefing session will be Louis C. Murray, M.D., Chairman of the Council on Legislation, to be followed by a description of the 1985 legislative outlook and issues by Tom Wood, M.D., Chairman of the Committee on State Legislation, and a presentation on an Auxiliary project by Mrs. Carolyn Spore, FMA-A Legislative Chairman. Other subjects to be covered are non-tort reform issues, the AMA Washington Report and a legislator's view of the 1985 Session. The Conference will adjourn at 11:30 a.m.

Additional meeting details will be reported in the Graypaper and other FMA publications.

FMA endorses conference on care for the elderly

"Alliance For Care," a national conference on community-based long-term care for the elderly, is planned for March 5-8, 1985 at the Hyatt Regency in Miami. Co-sponsored by the Stein Gerontological Institute of the Miami Jewish Home and Hospital for the Aged, and the Area Agency on Aging of Dade and Monroe Counties, the conference has been endorsed by over 40 national, state and community organizations, including the Florida Medical Association. The conference keynotes community initiative interagency co-operation, family and individual involvement and service provider pluralism. It will focus on what can be done now, under current constraints, to improve community-based long-term care. Attending will be representatives from government, human services provider agencies, retirement communities, consumers of services, national organizations for elderly advocacy, third party payers and other interested groups.

Major issues to be addressed include: Financing of Community-Based Long-Term Care; Developing Quality Delivery Systems: Case Management and Structure of Community-Based Long-Term Care; Cost-Effective Approaches; Role of Medical and Non-Medical Providers; Collaborative, Multi-Institutional and Interdisciplinary Strategic Planning.

For more information contact Ms. S. Hamilton, Director of Education and Training, Miami Jewish Home and Hospital for the Aged, 151 NE 52nd Street, Miami, FL 33137, (305) 751-8626.

DEAN'S MESSAGE

Economic grand rounds

The Prospective Payment System, implemented one year ago by the federal government, has mandated that we change the way we practice medicine. We must be more cognizant of all components of patient care, length of hospital stay, utilization of diagnostic services and outpatient facilities. Eighteen months ago, the medical and administrative staffs of the University of Miami/Jackson Memorial Medical Center were faced with the problem of preparing one of this nation's largest teaching hospitals for the implementation of the Medicare Prospective Payment System.

The 1,250 bed hospital has over 1,000 full time faculty and house staff as well as 1,300 registered nurses. Effective communication of even the simplest piece of information to all members of the staff is difficult. Fortunately, all clinical services have extremely active teaching programs, including grand rounds, M&M conferences, and a variety of multidisciplinary conferences.

The Quality and Utilization Control Department decided to embark on a series of teaching rounds, "Economic Grand Rounds," in order to prepare the Medical Center for the DRG methodology. Our objectives were to change physicians' attitudes and practice patterns in order to effect a new awareness of the importance of cost containment within the framework of the system's requirements and constraints.

The Quality and Utilization Control Department identified both clincial and administrative issues in the hospital that affected patient care costs, resource consumption, and efficient service delivery. Costs, charges and length of stay data by DRG were developed for our hospital and compared, when available, to national averages. A list of problem DRGs was developed for each clinical service. The clinical services were asked to impact particularly in those areas where length of stay and costs appeared to be excessive.

There were told that all DRGs could not be profitable but that any economics effected would help prevent a total economic loss under the system.

At Economic Grand Rounds, the methodology, terminology, construction, and "rules" of the Prospective Payment System were introduced. Each service was then presented with its own DRG data on costs, length of stay, reimbursement, projected profit or loss. A typical patient in a representative DRG of that service was presented with a case summary and an analysis of that specific patient bill. A method had been developed to partition bills into eight standard categories, such as: daily stay, O.R. charges, drugs, laboratory, supplies, radiology, advanced therapy and advanced diagnostics. Thus, patient's costs were compared to the average costs for all patients in a particular DRG at our hospital. Each area was then analyzed in the context of that patient's clinical course and areas where cost savings could be effected. Examples of action taken include timely and more effective discharge planning for decreased length of stay or influencing the utilization of laboratory tests.

The efforts are educational and presented in an informative manner at Economic Grand Rounds. They are not punitive. The medical, nursing and auxiliary staffs have made every effort in areas under their control to bring about changes. Representatives of hospital administration attend each session and are responsive to the systems, personnel and resource needs of the staff. A cooperative effort characterizes what has transpired. This presentation gave each physician an idea of how medical decisions translate into costs to the hospital and the patient. All the assembled participants, medical and administrative, discussed these findings and made recommendations to improve both physician and hospital performance and make better use of increasingly scarce resources.

The effectiveness of this program is obviously difficult to measure. Certain parameters have, however, indicated that it is working. Overall, hospital length of stay has decreased by approximately one day. Reimbursement, so far, under the Prospective Payment System has not resulted in a net loss. Preoperative length of stay for all patients has decreased. In other areas, a new antibiotic order form includes antibiotic costs for greater awareness. An innovative program for IV antibiotic therapy administered through home health care has been implemented and resulted in a significant net savings to the hospital.

We have seen a significant increase in the utilization of home health care agencies and the utilization of same day surgery, standing orders for lab and x-ray have been eliminated or revised in many areas, and, most importantly, an ongoing constructive dialogue has been established between house staff, attending staff, and administration.

We are convinced that a cooperative environment can be created between physicians and the hospital to assure that quality patient care can be provided in the most cost effective manner. For the first time, positive incentives have been created in the reimbursement system and it is vital that all members of the health care team participate in assuring its success.

Charles Lynne, M.D.
Associate Professor of Urology
University of Miami School of Medicine
Associate Medical Director of the
Quality & Utilization Control Dept.
Jackson Memorial Hospital

Marlene Rifkin, M.T., M.S.
Administrator of the Quality
and Utilization Control Dept.
Jackson Memorial Hospital

Fred J. Cowell, President
of the Public Health Trust

Bernard J. Fogel, M.D.
Vice President for Medical Affairs
and Dean
University of Miami School of Medicine

WORTH REPEATING

DCMA and alternative delivery systems

There is great concern by the membership of DCMA about alternative health care delivery systems. There are many members who would like for the DCMA to come out with a strong statement condemning pre-paid health plans. The anti-trust laws prevent us from doing this.

Furthermore, the Judicial Council of the AMA in 1984 stated:

> Competition between and among physicians and other health care practitioners on the basis of competitive factors such as quality of service, skill, experience, miscellaneous conveniences offered to patients, credit terms, fees charged, etc., is not only ethical but is encouraged. Ethical medical practice thrives best under free market conditions when prospective patients have adequate information and opportunity to choose freely between and among competing physicians and alternate systems of medical care.[1]

The policy of the DCMA is dictated by the elected representatives, the Board of Directors. As President, I have carried out and will continue to carry out that policy. These are very difficult times

for medicine. Things are changing rapidly and causing all of us great concern. There are very emotional times and practitioners are afraid that many of the changes will destroy them.

Yet, pre-paid health plans have been around for many years. Kaiser Permanente in California has been successfully operated for over 30 years and private fee for service medicine in California has continued to flourish.

Let us not forget that hundreds and hundreds of DCMA members are listed in some type of pre-paid alternative health plan. Hopefully, there is room for all types of alternative care in Dade County.

Some members have stated that there is a big difference between an HMO, PPO, or IPA. Indeed, there are differences. However, the bottom line is that all pre-paid plans take patients out of the private pool and all pre-paid plans offer discount medicine.

What the DCMA can do in this situation is to create a media plan to educate the public to the differences between a pre-paid health plan and private fee for service practice so that people will be able to choose wisely. Such a plan is being created at the direction of the DCMA Board of Directors.

Furthermore, the DCMA will continue to investigate any compliants of poor quality of care and work to see that corrections are made. The DCMA will investigate all complaints of false or deceptive advertising, and if found, take measures to correct them.

I strongly favor private fee for service practice and believe it will survive in an area where there are alternative health care delivery systems.

1. Current Opinions of the Judicial Council of the American Medical Association — 1984, 6:10, page 26.

A. Frederick Schild, M.D.
Miami

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Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

Hope and help for substance abuse prevention

Florida Medical Association Auxiliary members are "in action" to prevent the spread of substance abuse. The Civic Subcommittee of the Florida Commission on Drug and Alcohol Concerns was organized to coordinate the efforts of the volunteer community. Governor Bob Graham appointed Mrs. Priscilla (Bruce) Gerber, Immediate Past President of the FMA-A, to represent the Auxiliary on the Subcommittee and when asked about our role she quoted an expert, Peter Bell: "The community that clearly defines its standards for appropriate use, clearly communicates those standards to its members, and carefully monitors compliance with those standards, is the community with the fewest incidents of alcohol/drug related problems."

Chemical Awareness Week was declared for November 11-17. Detailed information on twelve positive and creative suggestions for preventive action for parents and teenagers trying to cope in our drug-oriented culture are available through Florida Informed Parents, Inc., 1323 Miccosukee Road, Tallahassee 32303. Bright green buttons which state in white letters "JUST SAY NO" are also available. How simple, how effective, the ultimate prevention. . ."JUST SAY NO."

An article in *Community Intervention*, Special Edition, Vol. II remarks: "Prevention is working, but is still has a long, long way to go. A recent analysis of seven year trends points to a clear decline in the use by adolescents of many illegal drugs. Alcohol use among teenagers remains stable at a very high level." A copy of this article may be obtained through Community Intervention, Inc., 529 South Seventh Street, Suite 570, Minneapolis, Minnesota 55415.

Everyone is aware of human suffering and social costs resulting from substance abuse but awareness alone is not enough. It will not save the life of an adolescent hooked on drugs, nor keep a family from being destroyed by alcoholism. As this insidious disease marches across our country, attacking persons of all ages and in all levels of our society, we in the medical community have a grave responsibility to recognize the subtle, masked symptoms of addiction and alcoholism, to help raise the blind of denial, and to encourage early intervention and treatment.

Prevention is the ideal goal and well worth the effort. Knowledge and networking are prevention's greatest allies. Once the disease has struck, we need to know what can and must be done: recognize the problem, understand the problem, care about the problem, and respond appropriately. The bad news is that we have a drug epidemic; the good news is that we have hope and help. We can be a vital part of that help through awareness, knowledge, and action based on education, research, prevention, and rehabilitation. Let us move forward with creative energy and enthusiasm to protect our nation and our world from drug destruction.

Sources for Substance Abuse Prevention

1. Florida Commission on Drug and Alcohol Concerns, Office of the Governor, Room 207, The Capitol, Tallahassee 32301-8047
2. National Federation of Parents for Drug Free Youth, 1820 Frannal Avenue, Silver Spring, Maryland 20901, 1-800-554-KIDS
3. Operation Cork, The Kroc Foundation Project Cork, 8939 Villa LaJolla Drive, Suite 203, San Diego, California 92037, 1-800-421-0353
4. Up Front, Inc., Up Front Drug Information, Coconut Grove Station, P.O. Box 330589, Miami 33233-0589, (Dade County) 1-305-446-3585, (outside Dade County) 1-800-432-8255

Mrs. Nancy (Clifford B.) Miles
FMA-A Substance Abuse Chairman
Pompano Beach

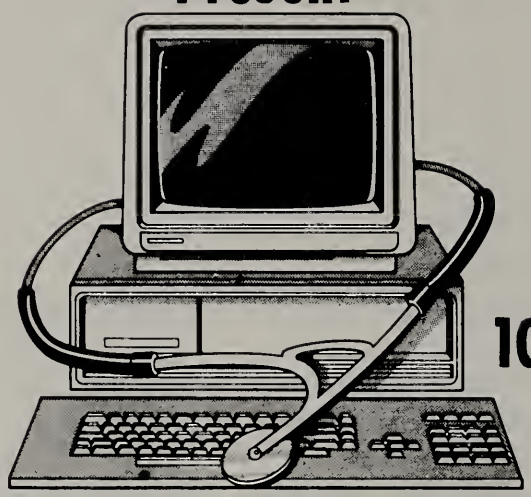


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